Medicaid Management Information Systems FY 1985 System Performance Review

June 1984

Information Resource Center

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BOC REFERENCE

HEALTH CARE FINANCING ADMINISTRATION

MEDICAID MANAGEMENT INFORMATION SYSTEMS

FY 1985 SYSTEM PERFORMANCE REVIEW

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11400. BACKGROUND AND AUTHORITY

Section 1903(r) of the Social Security Act provides an explicit basis for developing and applying performance standards to previously approved Medicaid Management Information Systems (MMIS). It requires HCFA to conduct standards-based reviews at least annually and to use the results of those reviews as the determining factor for both reapproval/disapproval of a State's MMIS and any resultant reductions in FFP levels. The reviews will be integrated, to the extent practicable, into the annual State Assessment process.

11405. SYSTEM PERFORMANCE REVIEW (SPR) BASIC PURPOSE

The basic purpose of the SPR program for MMIS is to improve the effectiveness and efficiency of the Medicaid program on an individual State basis and for the program overall. Performance evaluation is based on the concept that an MMIS must meet specific functional requirements, as well as certain performance standards. Thus the evaluation system applies measures which enable determinations to be made as to whether or not a State system satisfies the functional requirements and statistical levels of output relating to accuracy and timeliness. Initial approval of a State's MMIS does not guarantee automatic reapproval. The reapproval process begins anew each fiscal year and is intended to measure sustained performance, as opposed to the capabilities assured by the initial approval review. The SPR will be conducted by the ROs utilizing a standard format.

11405.1 Evaluation Mechanisms for States—Paragraph 1903(r)(6)(D) of the Social Security Act requires HCFA to insure that review procedures, performance standards, and other requirements for MMIS reapproval be of a nature which will permit their use by the States for self-evaluation. Accordingly, in addition to meeting the statutory requirement that the States be notified in advance of the actual review of those standards against which their MMIS will be measured, an underlying principle in both the issuance of the performance standards and the development of the accompanying instructions concerning assessment methodology has been to enable States to evaluate their own performance on an ongoing basis and take corrective action as needed. Thus, this section of the State Medicaid Manual (SMM) includes specific instructions on scoring, sampling, and methods of evaluation so that States may understand these techniques and apply them in conducting internal reviews of their own systems. States which wish to conduct internal SPRs might have to make adjustments in their record keeping or management information control systems. Upon request HCFA ROs will provide technical assistance to States in setting up such internal evaluation mechanisms.

11405.2 Automated File Search and Review Techniques.—Previous evaluation of the benefits and problems associated with manipulation of live files revealed that implementation of automated review procedures is beneficial to both HCFA and the States. Not only is the review burden eased for both, but States then have these processes available for ongoing use. Because the latter is an express objective of Section 1903(r)(6)(D) of the Act, HCFA has required since FY 1984 that States provide automated sampling capabilities for the SPR. If an individual factor requires automated sampling, it is indicated in the method of evaluation. When requested, ROs will provide States with technical assistance on this issue.

11405.3 Content and Utilization of SPR Instructions.—The SPR package contains performance standards and review elements together with the methodologies for assessing whether they are met. Also included are sampling methodologies used for evaluating program elements. Additional instructions, designed to provide more detailed guidance to the reviewers and greater uniformity of reviews nationwide, are currently under development. These supplemental instructions will be included in the HCFA Regional Office Manual. For MMIS States SPR replaces the Claims Processing target area of the State Assessment Guide. In addition, where an SPR factor duplicates a State assessment element in target areas other than Claims Processing, the SPR package takes precedence and the State Assessment element will not be reviewed. SPR reviews MMIS operations as integrated into overall State Medicaid program administration. Consequently, the SPR may include assessments of functions which are not historically considered part of the MMIS per se, but which are so crucial to Medicaid operations that an otherwise effective MMIS is of significantly reduced value if State performance of the function is deficient. Effectiveness and efficiency are evaluated in consideration of the total State operation.

11405.4 SPR Factor Weights and Scoring System.—The review factors are weighted to reflect relative importance within each element. A scoring mechanism incorporating the weights is provided to determine the degree of acceptable or failing performance. The scoring mechanism contains a tolerance so that for many factors poor performance, to a limited degree, will not result in failure of an element. However, significant failure of certain factors may result in failure of an element. The scoring system provides bonus points for superior achievement in certain functions and penalty points for failure to meet minimum levels of acceptable performance. Bonus points are awarded only if the initial score for an element is passing. Penalty points are assessed against each factor and always figure into the final score for each standard. That final score permits HCFA to distinguish between the performance of the individual State systems and is the principle determinant in the decision of MMIS reapproval or disapproval.

11405.5 Scheduling of SPR Reviews.—Review of State performance may be scheduled at the discretion of the ROs in coordination with the States. However, problem areas such as failure of a standard or element during a previous review period and suspected problems which could cause failure of the SPR must be reviewed before the end of the second quarter each year. The early review of problem areas ensures State awareness of deficiencies in time to take remedial action. In addition, State systems subject to SPR for the first time must be reviewed against all standards during the first two quarters. Certain factors, however, can not be completely reviewed until the fourth quarter; e.g., Medicaid Minimum Data Set (MMDS) reports. All evaluations are based on performance from the beginning of the period until the date of review.

Standards are normally evaluated only once during a review period. However, equity requires HCFA to be sure that failure of a standard is not due to a premature conclusion on overall performance. If a standard is reviewed early in the year and meets requirements, the result is normally considered final. If, however, the State's early performance results in failure of the standard, a subsequent review based on at least six (6) months activity is conducted on those factors which were assessed penalty points. This

procedure assures the States that any evaluation of deficiency is representative of overall performance. It also affords States an opportunity to correct problems so that overall performance for the review period may be acceptable. Where possible, failures should be fully explained in exit conferences. In any case, States are notified of initial findings of failure as early as possible. The RO and State work out, given State capabilities and RO staff resources, a mutually agreeable time for the rereview. Rereviews should be scheduled so that the States may take remedial action which would improve their annual performance rates. It is, however, impossible to conduct all rereviews late in the fourth quarter. Where agreement on a rereview date cannot be reached, the RO will schedule the rereview based on its best judgement as to the most appropriate time.

States should be aware that ROs will continue to monitor standards passed on early reviews to ensure that the State's performance in those areas continues at an acceptable level. If an RO, through such monitoring or other sources, has evidence that performance in an area earlier evaluated as acceptable may no longer meet performance standards, it may conduct a subsequent year to date review of affected factors.

11405.6 Availability of SPR Documentation.—Under SPR, documentation must be available to support alleged procedures. Some States may need to modify their internal record keeping requirements in order to provide adequate documentation of system performance. Further, when ROs determine that proper conduct of SPR requires access to the raw data upon which reports, tallies, etc., are based, the State must provide such data. If a State lacks, or is unwilling to provide, the necessary supporting documentation, the State will not be automatically presumed to have met the SPR requirements. Without documentation to support that a function was performed, maximum penalty points will be assessed for the appropriate factor(s). Special funding will not be available to the States for costs incurred due to SPR. Finally, the State Agency is ultimately responsible for meeting all standards, system requirements, or other conditions of reapproval as established by regulations. Thus, a State is not relieved of its responsibility merely because it uses the services of a proxy (fiscal agent, subcontractor, other State government component, etc.) to carry out certain functions.

The SPR results reflect the performance of States' MMIS and form the basis for resultant decisions on enhanced Federal funding levels. Because of the potential fiscal impact on States, it is imperative that the review methodologies and results for each factor be carefully documented by ROs to support their findings and conclusions.

11405.7 States' Flexibility Under SPR.—States have expressed concerns on the perceived use of the MMIS General Systems Design (GSD) as an SPR evaluation tool. The concept of demonstrable conceptual equivalence to MMIS requirements has been recognized since the inception of both MMIS and the SPR. This provision permits States to depart significantly from the GSD model so long as those changes satisfy the objectives and functions of the system requirements articulated in Part 11 of the SMM. This provides States sufficient flexibility to allow for the differing administrative needs of their various programs. State flexibility was further emphazied in the December 28, 1983 issuance to State Medicaid Directors describing the HCFA S/URS-MARS burden reduction initiative.

The SPR uses Part 11 as a source for basic MMIS requirements. However, changes in program needs require MMIS standards, systems requirements and guidelines to be subject to change at appropriate times. Consequently, what may have served as a demonstrable conceptual equivalent for FFP purposes at one time in a State, may necessarily be insufficient later on. This can also affect SPR performance if a previously accepted demonstrable conceptual equivalent is no longer justifiable in light of current reapproval requirements. The SPR is provided to the States by the end of June each year with an effective date of the following October. Thus, States have at least three (3) months advance notice of changes in the performance standards and review guidelines which might require modifications to State systems or procedures. States should read each new SPR carefully to identify potential problem areas. Questions concerning the proper interpretation of SPR requirements should be quickly directed to the ROs so as to permit maximum State reaction time.

11405.8 Other Mechanisms to Improve Performance.—State systems are expected to operate at the highest possible levels of efficiency and effectiveness. Marginally acceptable performance is not sufficient. While the SPR process is HCFA's principal vehicle for ensuring optimal levels of system performance, ROs have authorization to utilize, in addition to SPR, other oversight and remedial mechanisms. Examples of such mechanisms include focused reviews and corrective action plans. These may be used even where a State's MMIS has met all standards for reapproval. That is, a passing score on an individual standard does not absolve the State of its responsibility to continue to improve where possible. Nor does it absolve HCFA of its responsibility to work with the States toward that goal. However, system operational funding is not affected by these actions. Funding levels may be modified only in response to overall performance as determined in a formal SPR review.

11405.9 Monitoring Only Items.—New performance requirements may be added to the SPR at any point in the review cycle so long as their results cannot affect State funding. Such monitoring only items are often included to determine the feasibility of measuring a particular process or requirement in future SPRs.

11410. SYSTEM PERFORMANCE REVIEW SAMPLING METHODOLOGY - GENERAL

SPR sampling follows a scientifically valid sampling method. There are four sample size schedules which may be used: expanded, intermediate high, intermediate low, and normal. In addition, there are alternative samples to be utilized for certain critical factors. Factors using expanded and normal sampling are so marked. Intermediate high and low sampling are used as derivatives of expanded sampling for the samples used to measure multiple factors. These sampling methodologies significantly limit the amount of work required in the selection and analysis of samples. The relatively small sample sizes broaden the range of acceptable performance for meeting the standards. That is, given the lower precision of small samples, the scoring system gives the full benefit of increased doubt to the States. This adjustment is built into the scoring charts.

Where a factor involves sampling, it is necessary to use the sample size chart. To use the chart, determine the universe size for the portion of the year under review. For example, if the factor is being reviewed in March 1985, determine the universe size for the period October 1984 through March 1985 (up to the point of review). The sample size used is

found under the sampling plan column; i.e., expanded, intermediate high, intermediate low, or normal, in the same line as the universe size. For example, if the universe size is 350, the expanded sample is 70, and normal is 8. The only situation where universe size does not translate into various sample size groups is for factors having a prescribed large sample. The largest fixed sample will apply only to factors having an assumed large universe.

Intermediate high or low samples are required when the items measured are a subset of an existing expanded sample. The number of relevant items included in the expanded sample determines whether high versus low intermediate sampling and scoring is used. When 60 to 79 relevant items are sampled, use intermediate high sampling, when 40 to 59 relevant items are sampled, use intermediate low sampling. In either case, the number of items reviewed is exactly 60 or 40. This is achieved by randomly deleting excess relevant items to arrive at the highest possible intermediate sample size. Use the following procedure to eliminate excess items:

A. Assign consecutive sequential numbers from 1 to M to each RELEVANT item, where M is the total number of relevant items sampled.

B. Select a random two-digit number between 1 and M from a random number table and eliminate the corresponding item. Where a random number corresponds to an item already deleted, select another random number.

C. Repeat this process until the remaining number reaches 60 or 40. This remaining intermediate high or low sample is reviewed in its entirety for the factor.

11410.1 Methods for Pulling Samples.—One of the considerations of a sampling plan is the adequacy with which the sample reflects the universe from which it is drawn. Therefore, of prime importance in any of the sampling techniques is that each item has the same probability of selection. In the event that problems in sampling arise, this consideration is foremost. Samples are drawn by, or under, the direct supervision of RO personnel. This serves a dual purpose. It ensures RO familiarity with State file contents and configurations and contributes toward an appropriately defined sampling frame. Whenever samples are pulled by State or fiscal agent personnel, RO supervision must be adequate to assure that the sampling plan was fully complied with and that no bias was introduced in either pulling the sample or prescreening the sample before submitting it to the ROs.

In States selecting automated samples it is unnecessary to reverify the validity of the established sampling procedure for each selection, provided the RO has made prior onsite validations of the methodology. This onsite validation includes reviews of software documentation, file structures, and logistical and statistical procedures as well as a careful review of initial sample outputs. Time frames and procedures for transferring automated sample outputs to the RO must be coordinated to ensure that the samples are received timely. Note that any changes to the established automated sampling methodology require a new RO validation.

A. Random Numbers.—The sampling frame (universe) is either represented by a list of some sort or small enough to obviate a list. A list must be complete and nonduplicative. On this list each unit can be assigned a serial number between 1 and the

frame (universe) size. To select the sample use random numbers. Random numbers are taken from books specifically published for this purpose or are computer generated. If the sample size is n, pick n random numbers between 1 and the frame (universe) size. If any random numbers picked are duplicative, pick substitutes.

If using the random number tables, mark off sets of columns according to the frame (universe) size. For example, if the universe size is 4268, mark off sets of columns which are four digits wide. Use only those numbers between 1 and 4268 to pick the sample.

To ensure randomness when using a book of random numbers, open the book to a "random" page. Place a pencil down to determine the working page to be used; i.e., the number upon which the pencil lands is the page number to use in selecting the random numbers. Then pick another random number for the column and still another for the row. Go to the working page, column and row and pick random numbers from that point.

B. Systematic Random Sample.—The frame (universe) size must be known, or closely estimated. Calculate a skip interval by dividing the frame (universe) size by the sample size and taking the integer portion of this quotient as the skip interval K. Use random numbers to find a starting point m between 1 and K, inclusive. Draw this mth unit and every Kth unit thereafter.

Example: Universe = 140
Sample size = 50 (expanded sampling)
Ratio = 2.8
K = 2

Random start number (from a table of random numbers) = 2

Pick the second item in the universe, then the fourth, the sixth, etc., until the end of the universe is reached (do not stop after the sample size is reached). This could result in an oversample of up to half the desired sample size. The largest oversample occurs when the skip interval is small and the decimal portion which is truncated is greater than .5. If an oversample occurs, randomly select out the number of excess items to reduce the sample to the desired size.

Use either the random number or skip interval method. However, the first method requires a knowledge of the exact frame (universe) size while the skip interval may be used with a good estimate of the frame size. HCFA uses the term frame (universe) because in some cases the frame will not be the "universe" to which we are estimating. For example, in the mailroom sample, the frame is 1 day's receipts, while the universe is the year's receipts.

Where the sampling frame size is not known or cannot be accurately predicted, it is recommended that the reviewer oversample to the extent necessary to ensure the minimum sample is selected. To accomplish this, use the smallest universe size estimate that could reasonably be expected. This will result in a conservatively small skip interval. If this procedure results in excessive sampling, the sampling excess may be randomly deleted. This oversampling procedure minimizes the risk of potentially costly supplemental samples due to sampling shortages.

C. Measurement Method.—If the physical dimensions of the items sampled are fairly uniform, the systematic (skip interval) sample method may be used in another way. An example is a file drawer of index cards, one per "case," of uniform thickness. If a sample size of 42 is needed and the universe is 90 inches long, we would have a skip interval of 2.1 inches. (It is not necessary to round off because an inch is a continuous measure.) The random start is a two digit number between 1 and 21, inclusive. After selecting the random number, apply the decimal point; e.g., if the number 07 is selected, the starting point is 0.7 inches from the front This method is not acceptable where the physical dimensions tend to vary.

D. Cluster Sampling.—Some frames or universes are naturally clustered. For example, claims or correspondence may be in file cabinets. If a sample size of 20 is needed, 20 file drawers may be selected at random and one claim or whatever may be pulled randomly from each drawer. Such a procedure may be used with mail bags, stacks of items, etc. However, each item must have an approximately equal chance of selection. Therefore, if some "clusters" have more items than others, use some method to "equalize" the probabilities of selection.

For example, a sample of 20 claims is pulled from a sampling frame of 30 mailbags; the 30 mailbags represent 30 individual clusters. Twenty eight (28) of the mailbags are half full and the remaining two (2) are completely full. To equalize the clusters you would take one half (1/2) of the claims from each of the two (2) full bags and separate them into 30 equal parts. Then one part would go in each of the 30 mailbags. (It is not necessary to count every item in the mailbags, approximations of volume are acceptable.) Randomly select 20 mailbags (with replacement) and take one (1) claim from each bag selected. When selecting from the bag vary the place of selection within the bag.

E. Stratified Sampling.-This method can be used when the universe sampled can be logically separated into two or more homogeneous groups or strata. The size of the universe and the individual stratum within the universe must be known. After determining how many items to sample from the universe, determine how many to select from each stratum. The sample selection from each stratum must be proportionate to the total sample as the stratum is proportionate to the universe. The selection within each stratum must be random.

For example, a sample is drawn of adjudicated claims stratified according to the dollar value of program expenditure by type of service. The total program dollar expenditure for all claims in the universe is $10,000.00. The dollar value by type of service is as follows: Inpatient care $5000.00, Physicians Services $2500.00, Outpatient Care $1500.00, Pharmacy $1000.00. Using the dollar values as a basis of stratification the sample proportion is calculated as follows: Inpatient Care $5000/$10,000 or 50 percent of total sample, Physician Services $2500/$10,000 or 25 percent of total sample, Outpatient Care $1500/$10,000 or 15 percent of the total sample and Pharmacy $1000/$10,000 or 10 percent of the total sample. Therefore, for this example to pull a stratified sample of 80 claims, 40 must come from Inpatient Care, 20 must come from Physician Services, 12 must come from Outpatient Care, and eight (8) must come from Pharmacy.

Whenever a stratified sample is used, the sampling plan must be submitted to central office for prior approval. This is to ensure uniformity of approach by all regions.

F. Limited Scope Samples.—In a limited scope sample, the material available for sampling on any given day represents the State's operation for only that day or a small number of days. Such a sample would not be regarded as valid from either the State or the Federal point of view. The probability of an error in judgment regarding State performance would be high. In order to obtain reliable results in such cases, three samples a year are necessary. These samples are taken at intervals as widely spaced as is practical.

In order to determine the total sample size for the year, estimate the universe size for the year under review. The year's sample size is in Chart A under the appropriate sampling plan in the same line as the projected universe size. Use this method only when prescribed within a MOE.

1. Methodology for Limited Scope Samples.—In pulling three (3) samples a year, the optimum plan involves three (3) different days of the week and no bias as to the part of the month. In addition, avoid two (2) pulls during the same month.

The following are examples of limited scope sampling plans.

Example 1 Expanded Sample:

visit 1: Monday	Early November - 26 items
visit 2: Friday	Mid-January - 27 items
visit 3: Tuesday	Anytime in July - 27 items

Example 2 Normal Sample:

visit 1: Thursday	Late October - 7 items
visit 2: Tuesday	Early December - 7 items
visit 3: Friday	Anytime in March - 6 items

Pull one-third (1/3) of the sample size necessary for the year each time and use valid sampling techniques to select samples. As a reminder, it may be possible in some cases to obtain material necessary for followup evaluation by mail, or it may be desirable to obtain this material at the time of the next sample.

G. Sampling Claims in the Mailroom.—In selecting samples from the State agency mailroom to test certain claims processing factors, some problems are created by any or all of the following: receipt of mail in multiple locations, multiple deliveries, Medicaid mail combined with other State agency mail or Medicaid claims mixed with general Medicaid correspondence, or mail not opened before distribution to the various Medicaid departments or returning mail to normal workflow.

As these situations are addressed, the basic premise in any method of sample selection is that each item should have the same probability of selection. Following are some suggestions. Other approaches are acceptable as long as the method chosen is practical and promotes the selection of an unbiased sample.

1. Multiple Deliveries In One Day.—If there are several deliveries during the day, do not retain the incoming mail in the mailroom until after the sample is selected. Since limited scope sampling will be used and the number of visits to select the sample is three (3), vary the times of each review so that each is made at a different time of day; i.e., early morning, mid-morning, late morning or afternoon.

2. Multiple Locations for Receipt of Mail.—Determine in advance all possible locations where mail is received routinely and includes all items from each location in the sampling frame. These items may be selected by using a skip interval based on the estimated volume of claims in all locations.

3. Medicaid Mail Combined With Other State Agency Mail or Medicaid Mail Contains Both Claims and Correspondence.—Select the sample after the initial sort into Medicaid and non-Medicaid mail or into Medicaid claims and correspondence. If an item is selected which does not belong in the sample, disregard it and select the previous or following item.

4. Mail Not Opened Before Distribution to Medicaid Components.—Although it is not necessary for the State to open and date stamp mail at the point of receipt, the State's procedures should require that the actual date of receipt is used to age the claim. If mail is not opened in the State agency mailroom, select the sample from unopened mail, open the envelope, photocopy the claim, then replace the item in the envelope, and return it to the point of selection for normal processing.

5. Returning Mail to the Normal Work Flow.—Take every precaution to maintain the integrity of the sample. Return claims sampled in the mailroom to the normal work flow in such a manner that they cannot be identified subsequently as items which are part of the SPR sample. For example, sampling from mail not opened before distribution as previously explained could create a problem. If the only envelopes opened when the Medicaid component receives the day's receipts are the items sampled for the SPR, this could bias the handling of these claims and thus violate the integrity of the sample.

H. Acceptance Sampling—Acceptance sampling is a measurement method which allows efficient testing for achievement of minimum performance levels. This methodology will be used as outlined below for factors 6K1 and 6K2; i.e., validation of State S/URS reviews. Where the universe of State reviews exceeds 25 employ the following acceptance sampling methodology to verify that the State met each quarter's minimum. The acceptance sample of 25 will be applied independently to each recipient or provider type category subject to sampling.

The following chart gives acceptance and rejection points for a sample of 25 from a given quarter's provider (by type) or recipient case reviews. If the State completed fewer than 25 reviews, validate the universe of all State reviews. If the State reports fewer reviews than the quarter's required minimum, no further review will be necessary to validate that quarter's count as the State automatically failed to meet the requirement. The validation of State reviews for those States reporting 25 or more reviews will be conducted independently for each quarter by provider type and for all recipients as outlined below.

	% Required to Validate Minimum								
	≤ 10%	20%	30%	40%	50%	60%	70%	80%	≥90% 1/
Acc	1	2	4	6	8	11	14	17	20
Rej	25	24	22	20	18	15	12	9	6

1/ See exception noted in step 3 below.

1. Determine the number of reviews the State reportedly completed for the group of interest (N).

2. Determine the minimum number required (M). Note: If M is greater than N, the State is concluded to have failed to meet the minimum and no further review is necessary.

3. Divide M by N to get the percentage of reviews which must be valid. Truncate percentages to the next lowest multiple of 10 percent; e.g., 57 to 50. This determines the applicable percentage column from the chart. Exception: If N - M is 5 or less, substitute this number, plus 1, for the rejection number, and 25 minus the difference for the acceptance number; e.g., if N = 32 and M = 30, the rejection number is 32 - 30 + 1 = 3 and the acceptance number is 25 - 2 = 23.

4. Select a random sample of 25 from the N reviews reported as completed.

5. Determine the acceptability of each reported review and keep a running tally of the cumulative number of acceptable and unacceptable reviews.

6. If the cumulative number of acceptable reviews equals the number under ACC in the appropriate percentage's column of the chart, the State is deemed to have met its minimum.

If the cumulative number of unacceptable reviews equals the number under REJ in the appropriate percentage column of the chart, the State is deemed not to have met its minimum.

At the point where a determination is made in regard to a required minimum, document the methodology and findings and proceed with the appropriate follow-up actions. In order to allow for a comprehensive assessment of the quality of State reviews, review the entire sample of 25 even if the decision on acceptance or rejection is made based on fewer than 25 reviews.

11410.2 Sample Sizes Chart

Universe Size	Expanded Sampling	Intermediate High Sampling	Intermediate Low Sampling	Normal Sampling
1 - 8	All	All	All	All
9 - 25	All	All/20	All/20	8
26 - 40	25	24	20	8
41 - 60	30	30	24	8
61 - 90	40	36	27	8
91 - 150	50	43	31	8
151 - 250	60	48	34	8
251 - 600	70	54	37	8
601 - 3200	80	60	40	13
3201 or more	80	60	40	20

In addition to the above sampling ranges Element 4G requires a fixed sample of 180.

11415. SYSTEM PERFORMANCE REVIEW SCORING METHODOLOGY - GENERAL

Passing a standard requires a minimum number of points depending on the number of elements within each standard. Those point levels are:

1 element - 44 points
2 elements - 88 points (no element score less than 38)
3 elements - 132 points (no element score less than 38)

To determine if the standard has been met, simply sum the final element scores for that standard. Note that passing every element is not required for passing a standard, except where a standard has but one element. It was necessary to create a "floor" (38 points) for performance at the element level to ensure an extremely low score in one element could not be compensated for through the bonus points of another element. Seventy-five (75) percent funding requires all system functions to meet minimum requirements.

Penalty points are assessed to each factor in which a State fails to meet minimum levels of acceptable performance. To determine the actual penalty amount for a factor, multiply the penalty point(s) times the factor weight.

Bonus points are assessed to each factor in which a State demonstrates superior achievement. To determine the actual bonus amount for a factor, multiply the bonus point(s) times the factor weight. Bonus points are awarded only after it has been determined that the element score is passing.

The starting score for an element is 50. The passing score for an element is 44. To compute the initial score, subtract the sum of the actual penalty amounts (penalty point(s) X factor weights) for an element from the starting score. If the initial score equals or exceeds the passing score (44), then the sum of the actual bonus amounts can be added to obtain the final score. If the initial score is 43 or less, the initial score becomes the final score and actual bonus amounts assessed cannot be awarded. (See section 11415.1B for additional instructions on the treatment of penalty and bonus points.)

The scoring for each factor depends upon whether sampling, some other form of numerical scoring, or a non-statistical type of evaluation is involved. The factor scoring mechanisms are explained in general terms below. Each factor in the element will spell out the type of scoring and weights used for that factor and any exceptions. In all cases, where a factor is "deemed met" (i.e., no true evaluation occurs) no penalty accrues, nor are bonus points awarded.

A "deemed met" situation occurs when a function intended for review is not performed, and not performing it is correct. For example, Factor 1B3 is intended to measure buy-in updates. Obviously, States who do not buy-in to Medicare would be "deemed met" because the function does not exist within the State's system. In these obvious situations "deemed met" can be awarded without consultation, but in all other situations ROs must first consult with the Bureau of Quality Control before a "deemed met" factor score can be awarded. If a function intended for review is not performed, and not performing it is

incorrect, maximum penalties are assessed according to the factor scoring methodology. Because all evaluations are based on performance from the beginning of the period until the date of the review, scoring should be based on the entire period of the review, even if the State did not perform the relevant functions for that entire period. Moreover, where reports, profiles, or similar items are being reviewed, all such items or their demonstrable conceptual equivalents, even if not produced, must be included in the universe for sample selection. For example, if reports A, B, and C are required to be produced each quarter but are produced only in the fourth quarter, the universe for sample selection would be 12 (three reports multiplied by four quarters). If a report selected in the sample was not produced, maximum penalty points would be assessed.

11415.1 Methods for Scoring.—The instructions in this section and in the preceding §11415 are followed for scoring the SPR.

A. Factor Scoring.—Scoring, unless otherwise specified in the factor instructions is done according to Charts A-F. Chart A gives the score (bonus or penalty points) awarded based on the percentage of items correct in a fixed or expanded sample. Chart B gives the score awarded based on the percentage of items correct in an intermediate high sample. Chart C gives the score awarded based on the percentage correct in an intermediate low sample. Chart D gives the score based upon the number of items incorrect in a normal sample. Chart E yields the score according to the percentage of items correct when an entire universe of 26 items or more is reviewed. Chart F provides for scoring universes of 25 items or less.

The charts have built-in tolerances to account for uncertainty resulting from sampling. This is true also for charts used for universe scoring because the universes being examined are not always the true universes and are subject to some degree of uncertainty. When a factor has a specific Acceptable Performance Level, this APL represents a range of performance for any given bonus/penalty point. For example, using expanded sample chart A1 and a 90 percent APL to get two (2) bonus points, the actual performance could be anywhere within the range of 95.1 percent to 100 percent. To get two (2) penalty points, actual performance for a 90 percent APL could range from 78.1 percent to 81.2 percent.

When a factor calls for special scoring, usually in assessing administrative procedures, make a determination based on review findings and assign points as follows:

Significantly exceeds requirements = 1 bonus point x the weight

Meets requirements = 0 points

Minor problems = 1 penalty point x weight

Uncorrected minor problems from previous review = 2 penalty points x weight

Major problems = 3 penalty points x weight

Uncorrected major problems from the immediately preceding review = 4 penalty points x weight

Defined scoring instructions are shown (defined) in the method of evaluation of individual factors, where the other scoring methods above do not apply or where they have been modified to more accurately evaluate performance.

B. Treatment of Decimals

1. Percentages.—Where performance is computed as a percentage, round the percentage correct in the sample or universe to one decimal place. Round up if the second decimal place is 5 or above; e.g., 95.46 = 95.5 and 93.24 = 93.2.

2. Penalty and Bonus Points.—In computing penalty and bonus points, round up if the decimal is 5 or above. Compute penalty points for each factor in the element, multiply by the weight, and round to one decimal place. Total all penalty points for the element, subtract from the starting score of 50, then round to the nearest whole number to give the initial score. Compute bonus points for each factor, multiply by the weight, and round to one decimal place. If the initial score is 44 or above, total all bonus points for the element, add to the initial score, and round to the nearest whole number to obtain the final score. If the initial score falls between 43.5 and 43.9, round up to 44 and award bonus points.

Worksheets are provided following Standard X which provide all necessary information to score State performance (see Appendix A). It will be necessary only to fill in the blanks to derive element scores. These scores will then be summed to determine if the individual standards have been met.

C. Examples of Factor Scoring

1. Expanded Sample Scoring

Acceptable Performance Level = 90%
Weight = 2
Universe size = 10,000
Sample size = 80

a. Using scoring chart A1, if the percentage correct in the sample is 83.5 - 90.0 the factor is passed. There are no penalty or bonus points.

b. If the percentage correct in the sample is less than 83.5, obtain penalty points from scoring chart A1. Thus, if the score were 79%, assess 2 penalty points times the weight (2): 2 x 2 = 4 actual penalty amount.

c. If the percentage correct in the sample is greater than 90, obtain bonus points from scoring chart A1. Thus, if the score were 95%, you would award 1 bonus point times the weight (2): 1 x 2 = 2 actual bonus amount. (Bonus points are awarded only if the element as a whole is passed.)

2. Fixed Sample Scoring

Acceptable Performance Level = 99%
Weight = 3
Universe Size = NA
Sample Size = 180

a. Using scoring chart A2, if the percentage correct in the sample is 97.5 - 100 the factor is passed. There are no penalty or bonus points.

b. If the percentage correct in the sample is less than 97.5, obtain the penalty points from scoring chart A2. Thus, if the score were 95%, assess 3 penalty points times the weight (3): 3 x 3 = 9 actual penalty amount.

c. Since the APL is 99%, no bonus points are available in scoring chart A2 for this example.

3. Intermediate High Sample Scoring

Acceptable Performance Level = 97.5%
Weight = 1
Universe Size = 10,000
Sample Size = 60

a. Using scoring chart B, if the percentage correct is 93.0 - 96.5 the factor is passed. There are no penalty or bonus ponts.

b. If the percentage correct in the sample is less than 93.0, obtain penalty points from scoring chart B. Thus, if the score were 88.0%, assess 3 penalty points times the weight (1): 3 x 1 = 3 actual penalty amount.

c. If the percentage correct in the sample is greater than 96.5, obtain bonus points from scoring chart B. Thus, if the score were 97.0%, you would award 1 bonus point times the weight (1): 1 x 1 = 1 actual bonus amount. (Bonus points are awarded only if the element as a whole is passed.)

4. Intermediate Low Sample Scoring

Acceptable Performance Level = 90%
Weight = 2
Universe Size = 5,000
Sample Size = 40

a. Using scoring chart C, if the percentage correct is 80.8 - 87.5 the factor is passed. There are no penalty or bonus points.

b. If the percentage correct in the sample is less than 80.8, obtain penalty points from scoring chart C. Thus, if the score were 72.5%, assess 3 penalty points times the weight (2): 3 x 2 = 6 actual penalty amount.

c. If the percentage correct in the sample is greater than 87.5, obtain bonus points from scoring chart C. Thus, if the score were 94.2%, you would award 2 bonus points times the weight (2): 2 x 2 = 4 actual bonus amount. (Bonus points are awarded only if the element as a whole is passed.)

5. Normal Sample Scoring

Acceptable Performance Level = 90%
Weight = 2
Universe size = 10,000
Sample size = 20

a. Using scoring chart D, if the number wrong in the sample is 4-6, the factor is passed. There are no penalty or bonus points.

b. If the number wrong in the sample is greater than 6; e.g., number wrong - 10, obtain the penalty points from scoring chart D. Thus, in this example there are 4 penalty points times the weight (2) for an actual penalty amount of 8.

c. If the number wrong in the sample is less than 4, obtain the bonus points from scoring chart D. Thus, if the number wrong is 2, award 1 x 2 = 2 actual bonus amount. (Note, again, that bonus points are awarded only if the element is passed.)

6. Universe Scoring

Acceptable Performance Level = 75% (based on total data, not sample data)
Weight = 2

a. Using scoring chart E, if the State scores 72.6 - 77.5%, factor is passed. There are no penalty or bonus points.

b. If the State scores less than 72.6% obtain penalty from Chart E. Thus if the score were 70%, assess 2 penalty points times the weight (2): 2 x 2 = 4 actual penalty amount.

c. If the State scores higher than 77.5%; e.g., 80% obtain the bonus points from scoring chart E, in this case 1, multiply by the weight (2) and award the total bonus, 1 x 2 = 2 actual bonus amount (if the element is passed).

7. Special Scoring

Weight = 2

a. If the State's performance is determined to be acceptable, the score is 0.

b. If performance is judged to need minor improvement, assess one penalty point times the weight: 1 x 2 = 2 actual penalty amount.

c. If performance reveals that minor problems from previous reviews remain uncorrected (and are well documented), assess two (2) penalty points times the weight: 2 x 2 = 4 actual penalty amount.

d. If performance is judged to be an outright failure or the activity to be reviewed is not performed at all, assess three (3) penalty points times the weight: 3 x 2 = 6 actual penalty amount.

e. If the review reveals major problems from the immediately preceding review which remain uncorrected (and are well documented), assess four (4) penalty points times the weight: 4 x 2 = 8 actual penalty amount.

f. If performance is significantly above basic requirements, award one (1) bonus point times the weight: 1 x 2 = 2 actual bonus amount.

8. Defined Scoring.—For some factors the methods of evaluation require unique scoring mechanisms. The penalty and bonus point calculations are spelled out for each of these factors.

11415.2 Expanded Fixed Sampling Scoring - Chart A

11415.2 Expanded Fixed Sampling Scoring - Chart A

A1 - Expanded Sample Scoring

Bonus/ Penalty Pts. \ APL	99%	97.5%	95%	90%	85%
	Percentage Points				
+2	-	-	-	95.1 - 100.0	92.6 - 100.0
+1	-	97.6 - 100.0	95.1 - 100.0	90.1 - 95.0	85.1 - 92.5
0	97.1 - 100.0	93.6 - 97.5	90.1 - 95.0	83.5 - 90.0	77.1 - 85.0
-1	95.7 - 97.0	92.3 - 93.5	88.1 - 90.0	81.3 - 83.4	75.1 - 77.0
-2	94.4 - 95.6	91.0 - 92.2	86.1 - 88.0	78.1 - 81.2	73.1 - 75.0
-3	93.1 - 94.3	89.7 - 90.9	84.1 - 86.0	76.1 - 78.0	71.9 - 73.0
-4	91.8 - 93.0	88.4 - 89.6	82.1 - 84.0	74.1 - 76.0	69.1 - 71.8
Penalty Formula for 5 or more Penalty Pts.	$\frac{1}{2}$(100.0 - PERF)	$\frac{1}{2}$(97.5 - PERF)	$\frac{1}{2}$(84.0 - PERF)	$\frac{1}{2}$(84.0 - PERF)	$\frac{1}{2}$(79.0 - PERF)

A2 - Fixed Sample Scoring

Bonus/ Penalty Pts. \ APL	99%	97.5%	90%
+2	-	-	95.1 - 100.0
+1	-	97.6 - 100.0	90.1 - 95.0
0	97.5 - 100.0	95.1 - 97.5	85.5 - 90.0
-1	96.3 - 97.4	93.8 - 95.0	83.0 - 85.4
-2	95.2 - 96.2	92.6 - 93.7	80.8 - 82.9
-3	94.1 - 95.1	91.4 - 92.5	78.6 - 80.7
-4	93.0 - 94.0	90.2 - 91.3	76.4 - 78.5
Penalty Formula for 5 or more Penalty Pts.	.75(99.6 - PERF)	.65(97.8 - PERF)	.5(86.3 - PERF)

NOTE: Bonus or penalty points must be multiplied by weight of the factor. For treatment of decimals, see section 11415.1B

11415.3 Intermediate High Sample Scoring - Chart B

	Minimum Sample Size 20	Maximum Sample Size 60	
	99%	97.5%	90%
2 Bonus	-	-	94.6 - 100.0
1 Bonus	-	96.6 - 100.0	89.1 - 94.5
0	96.5 - 100.0	93.0 - 96.5	82.5 - 89.0
1 Penalty	94.5 - 96.4	91.3 - 92.9	79.9 - 82.4
2 Penalty	92.5 - 94.4	89.6 - 91.2	77.3 - 79.8
3 Penalty	90.5 - 92.4	87.9 - 89.5	74.7 - 77.2
4 Penalty	88.5 - 90.4	86.2 - 87.8	72.1 - 74.6
Penalty Formula for 5 or more Penalty Points	1/2 (99.0 - PERF)	1/2 (97.5 - PERF)	1/2 (82.0 - PERF)

11415.4 Intermediate Low Sample Scoring - Chart C

	Minimum Sample Size 20	Maximum Sample Size 40	
	99%	97.5%	90%
2 Bonus	-	-	93.8 - 100.0
1 Bonus	-	96.1 - 100.0	87.6 - 93.7
0	96.0 - 100.0	92.7 - 96.0	80.8 - 87.5
1 Penalty	93.8 - 95.9	90.8 - 92.6	77.9 - 80.7
2 Penalty	91.6 - 93.7	88.9 - 90.7	75.0 - 77.8
3 Penalty	89.4 - 91.5	87.0 - 88.8	72.1 - 74.9
4 Penalty	87.2 - 89.3	85.1 - 86.9	69.2 - 72.0
Penalty Formula for 5 or more Penalty Points	1/2 (97.0 - PERF)	1/2 (95.0 - PERF)	1/2 (80.0 - PERF)

NOTE: Bonus or penalty points must be multiplied by the weight of the factor. For treatment of decimals, see section 11415.1B

11415.5 Normal Sampling Scoring - Chart D

85% APL

Bonus/Penalty Points / Sample Size	+1	0	-1	-2	-3	-4 or over
	ERRORS					
8	0-1	2-3	4	5	6	
9	0-1	2-4	5	6	7	
10	0-1	2-4	5	6	7	
11	0-2	3-5	6	7	8	
12	0-2	3-5	6	7	8	One additional
13	0-2	3-5	6	7	8	penalty point
14	0-2	3-6	7	8	9	for each
15	0-2	3-6	7	8	9	additional
16	0-2	3-6	7	8	9	error over -3
17	0-3	4-7	8	9	10	level
18	0-3	4-7	8	9	10	
19	0-3	4-8	9	10	11	
20	0-3	4-8	9	10	11	
21	0-3	4-8	9	10	11	

90% APL

Bonus/Penalty Points / Sample Size	+1	0	-1	-2	-3	-4 or over
	ERRORS					
8	0	1-3	4	5	6	
9	0	1-3	4	5	6	
10	0	1-3	4	5	6	
11	0-1	2-4	5	6	7	
12	0-1	2-4	5	6	7	One additional
13	0-1	2-4	5	6	7	penalty point
14	0-1	2-4	5	6	7	for each
15	0-1	2-4	5	6	7	additional
16	0-1	2-4	5	6	7	error over -3
17	0-3	3-5	6	7	8	level
18	0-3	4-6	7	8	9	
19	0-3	4-6	7	8	9	
20	0-3	4-6	7	8	9	
21	0-3	4-6	7	8	9	

Note: Bonus or penalty points must be multiplied by the weight of the factor.

Normal Sampling Scoring - Chart D (Continued)

95% APL or 97.5% APL

Bonus/Penalty Point / Sample Size	+1	0	-1	-2	-3	-4 or over
	ERRORS					
8	0	1-2	3	4	5	
9	0	1-2	3	4	5	
10	0	1-2	3	4	5	
11	0-1	2-3	4	5	6	
12	0-1	2-3	4	5	6	One additional
13	0-1	2-3	4	5	6	penalty point
14	0-1	2-3	4	5	6	for each
15	0-1	2-3	4	5	6	additional
16	0-1	2-3	4	5	6	error over -3
17	0-1	2-4	5	6	7	level
18	0-1	2-4	5	6	7	
19	0-1	2-4	5	6	7	
20	0-1	2-4	5	6	7	
21	0-1	2-4	5	6	7	

99% APL
(No Bonus Points)

Penalty Points / Sample Size	0	-1	-2	-3	-4 or over
	ERRORS				
8	0-1	2	3	4	
9	0-1	2	3	4	
10	0-1	2	3	4	
11	0-2	3	4	5	
12	0-2	3	4	5	
13	0-2	3	4	5	One additional penalty
14	0-2	3	4	5	point for each additional
15	0-2	3	4	5	error over -3 level
16	0-2	3	4	5	
17	0-3	4	5	6	
18	0-3	4	5	6	
19	0-3	4	5	6	
20	0-3	4	5	6	
21	0-3	4	5	6	

Note: Bonus or penalty points must be multiplied by the weight of the factor.

11415.6 Universe Scoring - Chart E

Bonus/ Penalty Pts. \ APL	99.5%	99%	97.5%	95%
	Percentage Correct			
+2	-	-	-	-
+1	-	-	98.6 - 100.0	96.1 - 100.0
0	98.6 - 100.0	98.1 - 100.0	96.6 - 98.5	94.1 - 96.0
-1	97.6 - 98.5	97.1 - 98.0	95.6 - 96.5	92.7 - 94.0
-2	96.6 - 97.5	96.1 - 97.0	94.6 - 95.5	91.3 - 92.6
-3	95.6 - 96.5	95.1 - 96.0	93.6 - 94.5	89.9 - 91.2
-4	94.6 - 95.5	94.1 - 95.0	92.6 - 93.5	88.5 - 89.8
Formula for 5 or more Penalty Pts.	(99.5 - PERF)	(99.0 - PERF)	(97.5 - PERF)	0.7(95.5 - PERF)

Bonus/ Penalty Pts. \ APL	90%	82%	75%	50%
	Percentage Correct			
+2	95.6 - 100.0	92.1 - 100.0	90.1 - 100.0	80.1 - 100.0
+1	91.6 - 95.5	84.1 - 92.0	77.6 - 90.0	55.1 - 80.0
0	88.6 - 91.5	80.1 - 84.0	72.6 - 77.5	45.1 - 55.0
-1	87.1 - 88.5	78.1 - 80.0	70.1 - 72.5	40.1 - 45.0
-2	86.6 - 87.0	76.1 - 78.0	67.6 - 70.0	35.1 - 40.0
-3	85.1 - 86.5	74.1 - 76.0	65.1 - 67.5	30.1 - 35.0
-4	83.6 - 85.0	72.1 - 74.0	62.6 - 65.0	25.1 - 30.0
Formula for 5 or more Penalty Pts.	$\frac{2}{3}$(91.0 - PERF)	$\frac{1}{2}$(82.0 - PERF)	0.4(75.0 - PERF)	$\frac{1}{5}$(50.0 - PERF)

NOTE: Bonus or Penalty points must be multiplied by the weight of the factor. For treatment of decimals, see section 11415.1B.

11415.7 Small Universe Scoring - Chart F

Bonus/Penalty Points / Universe	+2	+1	0	-1	-2	-3	-4 or Worse
				ERRORS			
1	-	-	0	1	-	-	
2	-	-	0	1	2	-	
3	-	-	0	1	2	3	
4	-	-	0	1	2	3	
5	-	0	1	2	3	4	
6	-	0	1	2	3	4	One additional penalty point for each additional error over -3 penalty point level
7	-	0	1	2	3	4	
8	-	0	1	2	3	4	
9	-	0	1	2	3	4	
10	-	0	1	2	3	4	
11	-	0	1	2	3	4	
12	-	0	1	2	3	4	
13	0	1	2	3	4	5	
14	0	1	2	3	4	5	
15	0	1	2	3	4	5	
16	0	1	2	3	4	5	
17	0	1	2	3	4	5	
18	0	1	2	3	4	5	
19	0	1	2	3	4	5	
20	0	1	2	3	4	5	
21	0	1	2	3	4	5	
22	0-1	2	3	4	5	6	
23	0-1	2	3	4	5	6	
24	0-1	2	3	4	5	6	
25	0-1	2	3	4	5	6	

NOTE: Bonus or penalty points must be multiplied by the weight of the factor.

11420. SPR PERFORMANCE STANDARDS

The performance standards enumerated in §§11420.1-11420.7 cover the basic requirements of eligibility, support files, orderly, accurate and timely claims processing and review, MARS, S/URS, and general administration. The concept of demonstrable conceptual equivalence is used in assessing State performance and adherence to established system requirements.

11420.1 STANDARD 1 - ELIGIBILITY.—An Accurate System of Recipient Eligibility Information Must Be Provided.

A. Element A.—THE STATE MUST MAKE ACCURATE ELIGIBILITY DETERMINATIONS AND MUST BE RESPONSIVE TO PROVIDER REQUESTS FOR RECIPIENT ELIGIBILITY INFORMATION.

Factor 1A1: The State must provide and retain required eligibility file data.

Method of Evaluation

1. Review the States' current system specifications for the presence of required eligibility data elements as specified in Part 11 of the SMM, Chapter 3, §11375.1. Such elements are listed as data elements 1-24 (exclude UHDDS requirements) in that section.

2. Medicaid eligibility data, which should reflect data required by the above elements, must be retained for the entire claims filing period permitted under the State plan.

3. Use special scoring (see § 11415.1.). Because data elements 1 through 24 are the minimal system requirements no bonus points can be accrued for this factor. Weight is 2.

B. Element B.—THE STATE MUST MAINTAIN ACCURATE AND ADEQUATE FILES ON ELIGIBLE RECIPIENTS.

Factor 1B1: The State must integrate federally reported SSI data into the eligibility file accurately and timely. This measure is deemed met for non-1634 States.

Method of Evaluation

1. Review State procedures to determine the frequency and method (mail or Programmable Magnetic Tape Terminal (PMTT)) by which the State receives the federally produced State Data Exchange (SDX) transaction tapes. (Do not include the monthly treasury tapes.)

2. Select a normal sample from at least six (6) months of SDX transaction tapes. Review State logs to determine the actual dates of receipt of the SDX and the dates the data were input to the eligibility (social services) files.

3. Updates of SSI accretions, deletions, and record changes must be made within ten (10) working days of receipt of the SDX.

4. The Acceptable Performance Level is 95 percent. Weight is 1. Use scoring chart D.

Factor 1B2: All eligibility changes must be made available timely for claims processing use.

Method of Evaluation

1. Using normal sampling, select a sample of State transaction tapes. If the universe is eight (8) or less, the entire universe must be reviewed.

2. The regional office must validate that actual processing dates, rather than system assigned dates, are used.

3. Resultant updates to the claims processing eligibility file from the main eligibility file must be made within ten (10) working days of the update to the main eligibility file. If the main eligibility file is the result of an on-line update, the subsequent update to the claims processing eligibility file must be done at least every ten (10) working days.

4. Use defined scoring as follows:

a. One (1) bonus point if all tapes are processed within five (5) working days, or if the State MMIS directly accesses the main eligibility file for claims processing purposes.

b. Zero (0) points if all tapes are processed in six (6) to ten (10) working days.

c. One (1) penalty point for every tape processed after the 10th working day.

d. A maximum of six (6) penalty points may be accrued.

e. Weight is 1.

Factor 1B3: If a buy-in State, the buy-in data must be integrated into the eligibility or third party file on a timely basis.

Method of Evaluation

1. Review State tape control logs for eight (8) monthly buy-in tapes sent to the State by HCFA during the review period.

2. Verify that the tapes were processed to update the appropriate eligibility/third party file.

3. Use defined scoring as follows:

a. One (1) bonus point if all tapes were processed within 19 days.

b. Zero (0) points if all tapes were processed within 30 days.

c. One (1) penalty point for every tape not processed within 30 days.

d. A maximum of six (6) penalty points may be accrued.

e. Weight is 1.

Factor 1B4: If a buy-in State, the buy-in data must be accurately integrated into the eligibility and third party files.

Method of Evaluation

1. Use normal sampling. A sample of buy-in eligibles accreted or deleted within the current review period should be used. This will be provided by central office.

2. Verify that the appropriate eligibility/third party files contain accurate indicators.

3. The Acceptable Performance Level is 95 percent. Weight is 1.5. Use scoring chart D.

11420.2 STANDARD 2 - SUPPORT FILES.—An Accurate and Accessible System of Files Must be Provided to Support System Operations

A. ELEMENT C.—ACCURATE AND ADEQUATE FILES MUST BE MAINTAINED ON ELIGIBLE PROVIDERS.

Factor 2C1: The provider file must be updated timely with provider status changes.

Method of Evaluation

1. Use normal sampling. Select a sample of those providers that were added, deleted, or had a status change during the review period. Status changes are those changes to the provider file that affect a provider's (1) entitlement to payment, (2) amount eligible to be paid, (3) services for which payment can be made, and (4) mode of practice; i.e., solo, group, clinic, etc. Address changes and State-initiated file clean-up will not be evaluated. Note: For States which employ separate provider status and provider rate/pricing files, limit the scope of the sample to changes to the provider status file.

2. Determine the dates the status changes were approved, as defined by written State policy. Changes which do not require specific approval under State procedures are measured from the date of receipt by the State.

3. Check the date the provider's enrollment, update or disenrollment transaction was posted to the claims processing system. (Check audit trail, processing date, etc.)

4. Changes should be posted within ten (10) working days of approval or receipt as appropriate.

5. The Acceptable Performance Level is 99 percent. Weight is 1. Use scoring chart D.

Factor 2C2: Accurate provider eligibility files must be maintained.

Method of Evaluation

1. Check both Federal/State policy and State plan regarding licensure/certification of providers and/or individual provider agreements.

2. Select a normal sample of all providers (include those from out of State) on the current provider file requiring licensure/certification and/or provider agreements.

3. The State must be able to show that each sampled provider was properly licensed and/or certified on the date that the sample was selected.

4. Also verify that, where required, a current valid provider agreement is on file. (Disregard those provider types that use a claim as a provider agreement.) Count no more than one error per provider.

5. The Acceptable Performance Level is 99 percent. Weight is 1.5. Use scoring chart D.

Factor 2C3: A unique identifier must be provided for each enrolled provider to permit all services rendered to be adequately tracked.

Method of Evaluation

1. Select a normal sample of individual non-institutional providers.

2. Check the sample against the latest Alphabetic Provider Listing for duplicate names which have two numbers that are not cross-referenced. If this cannot be accomplished using only the alpha listing, check the sample against the Provider Listing by Group Affiliation.

3. Where duplicates are found, verify that no more than one (1) unique identifier was assigned. However, unique identifiers which can be determined to be modifiers (such as billing address keys or cross reference numbers) are acceptable and are not to be considered duplicates. Providers which submit teaching hospital claims and Medicare crossover claims may have duplicate identifiers; however, they should not be counted as errors.

4. The Acceptable Performance Level is 99 percent. Weight is 1.5. Use scoring chart D.

Factor 2C4: Providers which practice in group settings must be assigned individual rendering provider numbers (in addition to any group practice number). The automated system must collect all claims experience under the individual unique identifier for monitoring charges and payments and S/URS profiling purposes. This factor is deemed met in States which do not recognize groups as either providers, billers, or payees.

Method of Evaluation

1. Obtain a listing of all group practices, and select a normal sample.

2. Obtain a provider payment history for each of the selected groups. From the payment history randomly select a claim paid within the review period. If no claims were paid return to the group listing to select another group. Repeat this process until a normal sample of claims paid to groups is selected. If there is another source from which to sample claims paid to groups it may be used.

3. Verify that each claim paid to a group also carried an individual rendering provider number and that this number (in addition to the group number) is recorded in the system for the S/URS operation. Providers which submit teaching hospital claims and Medicare crossover claims may have duplicate identifiers, however, they should not be counted as errors.

4. The Acceptable Performance Level is 99 percent. Weight is 2. Use scoring chart D.

D. ELEMENT D.—ACCURATE PRICING FILES MUST BE MAINTAINED FOR READY ACCESS IN SYSTEM OPERATIONS.

Factor 2D1: Pricing file transactions must be posted timely.

Method of Evaluation

1. Review the State's written procedures for updating the pricing file to determine the approval process for changes.

2. Select a normal sample of pricing file updates. Collective updates using one medium (tape, disc, etc.) are counted as one (1) update. For States which employ separate provider status and provider rate files, include in the universe pricing file updates to the provider rate/pricing file.

3. Changes to the pricing file must be made either prior to the effective date or within ten (10) working days after final approval or receipt if approval is not required (red book changes, etc.). Compare the final approval date, receipt date or effective date as appropriate to the date the update was put into the system.

4. Inpatient hospitals and Long Term Care Facilities are excluded.

5. The Acceptable Performance Level is 95 percent. Weight is 1.5. Use scoring chart D.

Factor 2D2: The approved Medicaid payment for services and items must be accurately posted on the pricing file.

Method of Evaluation

1. Use the normal sample selected for Factor 2D1.

2. Verify that the amounts posted on the pricing file are accurate. The amount on the pricing file must be compared to the most recent source document indicating a change.

3. The Acceptable Performance Level is 99 percent. Weight is 1. Use scoring chart D.

11420.3 STANDARD 3 - ORDERLY/TIMELY CLAIMS PROCESSING.—Claims Must Be Processed In An Orderly and Timely Manner From Initial Receipt Through Issuance of Claims Determinations.

NOTE: For purposes of Standard 3 the date of receipt is operationally defined as a date not later than the date of the first workday following the day of actual mailroom receipt. In addition, for SPR purposes electronic media claims (EMCs) are defined as claims submitted on magnetic tape, floppy disc, cassette, etc., or by tranmission from remote terminal and CPUs.

A. ELEMENT E.—CLAIMS MUST BE CONTROLLED FROM RECEIPT THROUGH FINAL DISPOSITION, WITH TIMELY ISSUANCE OF COMPLETE CLAIMS DETERMINATION NOTICES.

Factor 3E1: Claims must be controlled with a unique identifier. A date of receipt must be shown on the claim. EMCs are excluded from this factor.

Method of Evaluation

1. Use expanded sampling to select a limited scope sample of claims (as defined in 42 CFR 447.45(b) and (c)(2)) from the mailroom. Make copies of the selected claims and return the originals to the mailroom.

2. Request documentation to verify that each claim has a unique identifier (or separate number, if used) incorporating the proper date of receipt. Claims should be receipt dated and uniquely identified by close of business on the workday following the day of mailroom receipt.

3. The State will have 30 working days from the date of the request to provide the documentation. The regional office representative should inform the State how the original claim or equivalent claim data should be transmitted if the documentation is not obtained onsite.

4. For claims which cannot be located, the State must provide documentation that the claim was returned to the provider. When a State system allows for returns prior to control, an unlocated claim meeting these written "early return" guidelines (as indicated by the sample copy) does not require documentation. If the return is not made according to guidelines, count one error. In all other States, if a claim cannot be located within 30 working days after the request, and there is no documentation to support that it was returned to the provider, count one error per claim. If a claim was not uniquely identified and/or dated properly count one error per claim.

5. The Acceptable Performance Level is 99 percent. Weight is 2. Use scoring chart A1.

Factor 3E2: EMCs must be controlled, entered into the System and/or rejected in a timely manner.

Method of Evaluation

1. Review State procedures for control and processing of EMCs.

2. Use a normal sample of submittal log entries. Review the selected entries to see that EMC submittals are recorded giving pertinent information such as sender I.D., date of receipt, date processed or rejected, etc. Include Medicare crossover claims if submitted via electronic media.

3. Take the above sample and compare computer run dates to determine if the submittal was entered in the next scheduled cycle (generally, the scheduled input of EMCs) or within six (6) working days, whichever is later. If the submission was rejected the submitter must have been notified within three (3) working days. The actual tape need not necessarily be returned within three (3) working days.

4. Review edits in the system to determine if all necessary elements are required in EMC submissions; e.g., procedure code, diagnosis, etc. Determine the error/missing data threshold for the system to reject a submission. Review the logs for rejected submissions to determine if the rejections were in accord with State policy.

5. Use special scoring (see §11415.1). Weight is 1.

Factor 3E3: EMC claims must be given unique identifiers and must show the actual date of receipt of the submittal.

Method of Evaluation

1. From the automated claims sample for Element G randomly select 20 EMCs or the actual number of EMCs, whichever is less. Verify that unique identifiers and correct dates of receipt are used by checking submittal logs or by checking the State's control and processing procedures.

2. If the assignment of unique identifiers and receipt dates cannot be verified using MOE 1 then use the sample of submittal logs in Factor 3E2 and randomly select one claim from each submittal. Verify that the claims in these submittals were assigned unique identifiers and correct dates of receipt.

3. If the recorded receipt date is later than the submittal receipt date plus one day count as an error.

4. If the claims are not assigned unique identifiers count as one error.

5. Count only one error per claim.

6. Acceptable Performance Level is 99 percent. Weight is 1. Use scoring chart D.

THIS FACTOR IS SCORED AND REPORTED FOR MONITORING PURPOSES ONLY IN FY 1985. OMIT FACTOR SCORE FROM COLUMNS "k" - "o" ON THE STANDARD SCORING WORKSHEET.

Factor 3E4: Timely and complete Explanation of Benefits (EOBs) must be provided to Medicaid recipients as required by Federal regulations.

Method of Evaluation

1. Select a normal sample of EOBs. Where a State furnishes EOBs for 100% of claims services, the sample may be selected as a subset of the adjudicated claims sample from Element G.

2. Compare these EOBs to the date of payment located on the recipient history or other appropriate file.

3. EOBs must be complete as required by regulation and must be produced within 45 days of payment.

4. Regulatory Citation: 42 CFR 433.113 (e) and (f).

5. The Acceptable Performance Level is 99 percent. Weight is 1.5. Use scoring chart D.

B. ELEMENT F.—CLAIMS MUST BE PROCESSED ON A TIMELY BASIS.

Factor 3F1: Ninety percent of clean practitioner claims must be paid or denied as appropriate within 30 days of receipt.

Method of Evaluation

1. Use the adjudicated claims sample from Element G.

2. Measure the time elapsed beginning with the date of receipt and through the date of payment (check date, not date of approval) or date on the denial notice.

3. Provider billings which qualify as practitioner claims are listed in Appendix C.

4. Regulatory citation: 42 CFR 447.45(d)(2).

5. The Acceptable Performance Level is 90 percent. Weight is 2. Use scoring chart A, B, C, or D as appropriate.

Factor 3F2: Ninety-nine percent of clean practitioner claims must be paid or denied as appropriate within 90 days of receipt.

Method of Evaluation

1. Use the adjudicated claims sample from Element G.

2. Measure the time elapsed beginning with the date of receipt and through the date of payment (check date, not date of approval) or date on the denial notice.

3. Provider billings which qualify as practitioner claims are listed in Appendix C.

4. Regulatory citation: 42 CFR 447.45(d)(3).

5. The Acceptable Performance Level is 99 percent. Weight is 2. Use scoring chart A, B, C, or D as appropriate.

Factor 3F3: Claims other than clean practitioner claims must be paid or denied as appropriate within 30 days as provided in the State Medicaid Manual.

Method of Evaluation

1. Use the adjudicated claims sample from Element G and review all claims not reviewed under 3F1 and 3F2.

2. Measure the time elapsed beginning with the later of the date of receipt or last error correction and through the date of payment (check date, not date of approval) or date on the denial notice. The various options for calculating processing time are detailed in Part 11 of the SMM, Chapter 3, §11325(c)(1).

3. The Acceptable Performance Level is 99 percent. Weight is 1. Use scoring chart A, B, C, or D as appropriate.

Factor 3F4: All claims must be paid or denied within 12 months of receipt.

Method of Evaluation

1. Use the adjudicated claims sample from Element G.

2. Measure the time elapsed beginning with date of receipt and through the date of payment (check date, not date of approval) or date on the denial notice.

3. Regulatory citation: 42 CFR 447.45(d)(4).

4. The Acceptable Performance Level is 99 percent. Weight is 1. Use scoring chart A.

11420.4 STANDARD 4 - ACCURATE CLAIMS PROCESSING AND REVIEW.—Claims Data Must Be Accurately Processed and Reviewed.

A. ELEMENT G.—CLAIMS DATA MUST BE PROCESSED ACCURATELY.

The claims processing measurement used in 4G1 for SPR scoring is the percentage of claims processed incorrectly. In addition to claim error data the region will capture, for all States, the dollar impact of the claims processed erroneously. Use this data in evaluating 4G2. These dollar findings determine a payment error rate which will dictate the CPAS required in the subsequent year. In non-mandatory CPAS States this estimate is a simple ratio of error payments to total payments in the adjudicated claims sample required for Factor 4G1. In mandatory CPAS States, the estimate is a separate stratified subsample regression estimate based on both State and regional reviews.

In both cases, the payment error rates are computed in central office. The statistical lower limit of these error rates is then derived. This lower limit is used on a State-specific basis to determine if the State meets the 1 percent and $1 million misspent tolerance. Failure of this tolerance requires implementation of a mandatory CPAS for the following year.

The sample for 4G is a systematic six month sample. One sampling interval is computed based on estimated universe counts and required sample sizes. The same intervals are used throughout the evaluation period to select monthly samples from each month's adjudicated claim universe. The intervals are NOT recomputed on a monthly basis. If the estimates of the universe are inaccurate and result in sampling of less than 175 reviewable claims or in excessive oversampling, contact central office for procedures to supplement or reduce the sample. (States using SPR for internal evaluation should contact the RO for assistance with such problems.)

Factor 4G1: Claims must be processed accurately and in accordance with regulation.

Method of Evaluation

1. Sampling

For all States obtain by automated means the monthly portion of a fixed sample of 180 adjudicated claims. In instances where the initial six month sample results in a marginal failure, it is possible that poor early year performance may be offset by improved late performance. In this instance the regional office may expand the fixed sample for up to two months beyond the base review period of October -March. In expanding this sample it is critical that the sampling intervals be held constant throughout the period. This will result in a final sample size of 240 adjudicated claims.

Where a failure of Standard 4 cannot possibly be overcome by the added two months' sample, no additional months will be reviewed. This point occurs with a six-month performance level of 86 percent.

2. Review

Review the claims according to the guidelines in Appendix B and record the findings on the "SPR Claims Processing Review Schedule" in Appendix B. Count the number of claims in the sample with one or more errors. Compute the percentage of claims without error. The Acceptable Performance Level is 97.5 percent. Weight is 3. Use scoring chart A-2.

Factor: 4G2: Claims must be paid accurately and in accordance with regulation and administrative procedure.

Method of Evaluation

a. NON-Mandatory CPAS States

1. Record the misspent dollars associated with claims reviewed for Factor 4G1 on the "SPR Claims Processing Review Schedule" in Appendix B.

2. Copies of the Claims Processing Review Schedule should be transmitted to central office so they can be received by June 15, 1985. The resulting lower limit of the payment error rate estimate will be disseminated to the regional offices to allow them to be added to the scoring sheets.

b. Mandatory CPAS States

1. Sampling and Reporting

If the regulation requiring operation of a CPAS is not published in the Federal Register by July 2, 1984, all States will use the above method of evaluation. If the regulation is published in the Federal Register by July 2, 1984, in mandatory CPAS States, select a 180 claim systematic subsample from the ongoing stratified State sample. The same stratum subsampling intervals are used throughout the evaluation period. This subsample will result in the selection of approximately 30 claims per month for the payment months of October through March of the assessment year.

2. Subsample Selection

State review findings are submitted to the region on a flow basis as reviews are completed. The subsample of 180 adjudicated claims is selected only from the submitted completed reviews. Any claims reviews not completed by the State due to their inappropriate selection in the sample will be validated and approved for exclusion by the region. An example of erroneously sampled claims is payments for 100 percent State funded programs.

As State review findings are received in the regional office, a systematic random subsample will be selected on a flow basis. This subsample will be selected independently for each stratum. This is accomplished by considering each stratum's subsample to be an independent systematic sample of all State reviews in the corresponding stratum. A single sampling interval is used throughout the evaluation period. The sample will be selected continuously from all State completed reviews submitted through the month. However, a new subsample random start number will be selected for the first completion list of each new month. The subsample of 180 claims is allocated to the strata in proportion to the estimated State sample size for each stratum.

3. Review

a. Review the claims using the guidelines in Appendix B and record the data on the "SPR Claims Processing Review Schedule" in Appendix B.

b. Copies of the Claims Processing Review Schedule should be transmitted to central office so they can be received by June 15, 1985. The resulting lower limit of the payment error rate estimate will be disseminated to regional offices to allow them to be added to the scoring sheets.

THIS FACTOR IS USED TO DETERMINE WHICH CPAS A STATE MUST OPERATE IN THE SUBSEQUENT YEAR. OMIT FACTOR SCORE FROM COLUMNS "k" - "o" ON THE STANDARD SCORING WORKSHEET.

B. ELEMENT H.—SYSTEM OPERATIONS MUST APPROPRIATELY INCORPORATE EDITS AND SCREENS.

Factor 4H1: Prepayment consistency and utilization edits/screens must be applied to all processed claims.

Method of Evaluation

1. Obtain the listing of State consistency/utilization edits. As a minimum there must be edits and audits that cross check between type of service, place of service, procedure code, diagnosis code, age, sex, frequency of service, provider type, or any appropriate combination. Systems which do not have the minimum edits in place as required in regulations will be assessed three (3) penalty points.

2. Regulatory citation: 42 CFR 447.45(f)(1)(ii).

3. If the State pays inpatient claims utilizing an all inclusive per diem rate, the edit(s) should check for duplicate outpatient claims. If this edit is not in place count as a minor problem.

4. Use special scoring (see §11415.1). Weight is 1.5.

Factor 4H2: Suspected duplicate claim submissions must be appropriately resolved.

Method of Evaluation

1. Use normal sampling to draw a limited scope sample of duplicate suspects (exceptions). Copy and return to the exception batch. If the State retains hard copy records on duplicate suspects going back to the beginning of the review period, a normal sample may be selected from this source.

2. Ten (10) working days or later request recipient histories for the excepted claims.

3. Compare the histories with the exception reports to verify that the State's duplicate resolution process resulted in appropriate action in each case.

4. Error definition - An inappropriate final action based on either improper application of State resolution procedures or a deficiency in these procedures which resulted in the incorrect action. Payment of outpatient claims which duplicate inpatient claims utilizing an all inclusive per diem rate is an error condition. Only one (1) error per claim, however, should be counted.

5. Regulatory citation: 42 CFR 447.45(f)(1)(iii).

6. The Acceptable Performance Level is 95 percent. Weight is 1.5. Use scoring chart D.

Factor 4H3: The use of force codes (override codes) must be controlled.

Method of Evaluation

1. Use normal sampling to draw a sample of claims adjudicated using force codes (resolved pends) or draw a limited scope sample of edit exceptions that were resolved via use of a force code. Exclude automated system overrides which do not require manual processing.

2. Use written State procedures to review claims to determine if the edits were properly overridden, i.e., use was authorized for the situation presented by the claim.

3. Review claims history to insure an audit trail to trace component users (not necessarily individual processing personnel) of the force codes exists. Both items 2 and 3 must be met for the claims to pass the review.

4. The Acceptable Performance Level is 99 percent. Weight is 1.5. Use scoring chart D.

11420.5 STANDARD 5 - MARS.—A Management and Administrative Reporting Subsystem (MARS) Must Be Efficiently and Effectively Operated In Order to Provide Support to Management Review, Evaluation and Decision-Making Processes.

A. ELEMENT I.—REQUIRED FEDERAL REPORTS MUST BE ACCURATE, COMPLETE, AND RECEIVED TIMELY BY THE REGIONAL OFFICE.

Factor 5I1: The HCFA-441 (Quarterly Medicaid Workload Report) and the HCFA-420 (EPSDT Report) must be received timely by the regional office.

Method of Evaluation

NOTE: If the HCFA-441 instructions are not issued prior to January 1, 1985, that report is not to be included in this factor's evaluation.

1. Compare the date of receipt of each report with the established HCFA due dates.

2. The date of receipt by the HCFA regional office must be recorded or stamped in a uniform way. The date of receipt must be no later than five (5) working days beyond the specified due date. This tolerance factor of five (5) working days represents an absolute. No additional good cause delays will be recognized. A blank report is considered to be a missing report, and penalty points will continue to accrue up to a maximum of six.

3. Manual citation: Part 11 of the SMM, Chapter 3, §11340(C).

4. Use defined scoring as follows:

a. All reports received before the due date = 1 bonus point

b. All reports received on the due date or within the tolerance = 0

c. One-seventh (1/7) of a penalty point will be accrued for each calendar day beyond the tolerance. To compute penalty points sum the total days late for all reports, divide by seven (7) and round to one (1) decimal point. Do not exceed six (6) penalty points.

d. For States with systems first subject to SPR in the current fiscal year, count one-fiftieth (1/50) of a penalty point for each calendar day late beyond the tolerance for all reports due in the first six (6) months of the State's review period. Subsequent reports should be measured according to MOE 4 (c). To compute penalty points: (1) Sum the total days late for reports due in the first six (6) months, divide by 50 and round to one decimal point; (2) Sum the total days late for subsequent reports, divide by seven (7) and round to one (1) decimal point; (3) Sum the results and do not exceed six (6) penalty points.

e. Weight is 2.

Factor 5I2: The annual HCFA-2082 must be received timely by the regional office.

Method of Evaluation

1. Items 1 and 2 of the MOE for Factor 5I1 should be used.

2. Manual citation: Part 11 of the SMM, Chapter 3, §11340(C).

3. Use defined scoring as follows:

a. Report received prior to the due date = 2 bonus points

b. Report received on the due date or within the tolerance = 0

c. One-fifth (1/5) of a penalty point is accrued for each calendar day beyond the tolerance. To compute penalty points sum the total days late, divide by five (5) and round to one (1) decimal point. Do not exceed six (6) penalty points.

d. For State systems first subject to SPR in the current fiscal year, count one-twentieth (1/20) of a penalty point for each calendar day late beyond the tolerance. To compute penalty points sum the total days late, divide by 20 and round to one (1) decimal point. Do not exceed six (6) penalty points.

e. Weight is 2.

Factor 5I3: The annual HCFA-350 must be received timely by the regional office.

Method of Evaluation

1. Items 1 and 2 of the MOE for Factor 5I1 should be used.

2. Manual citation: Part 11 of the SMM, Chapter 3, §11340(C).

3. Use defined scoring as follows:

a. Report received prior to the due date = 1 bonus point.

b. Report received on the due date or within the tolerance = 0.

c. One seventh (1/7) of a penalty point is accrued for each calendar day beyond the tolerance. To compute penalty points sum the total days late, divide by seven (7) and round to one decimal point. Do not exceed three (3) penalty points

d. For State systems first subject to SPR in the current fiscal year, count one twenty-eighth (1/28) of a penalty point for each calendar day late beyond the tolerance. To compute penalty points sum the total days late, divide by 28 and round to one (1) decimal point. Do not exceed three (3) penalty points.

e. Weight is 1.

Factor 5I4: The State reporting system must be operating to produce statistical reports in accordance with HCFA instructions. States subject to the data validation review must correct statistical reporting deficiencies brought to their attention.

Method of Evaluation

1. For those States that had a data validation review performed in FY 1984 the State must take corrective action on all deficiencies identified during FY 1984. Normally these corrective actions must be completed by the end of the FY 1985 review cycle. However, where a State can demonstrate that a longer period of time is needed to complete the corrective action, the completion date may extend beyond the closing date indicated above.

2. The State must provide documentation which indicates that the appropriate corrections were made. Findings not corrected within the review period will be scored in accordance with the review guide found in Appendix E entitled "Procedures for Validating Medicaid Statistical Data" unless the completion date has been extended and approved by the RO.

3. For those States that did not have a data validation review in FY 1984 because of initial certification, a data validation review will be performed in FY 1985 using the review guide found in Appendix E. Findings will be brought to the State's attention in FY 1985 for corrective action in FY 1986. For these States this factor is to be scored and reported for monitoring purposes only in FY 1985.

4. Weight is 1.5.

Factor 5I5: HCFA reports must be accurately completed in accordance with HCFA instructions.

Method of Evaluation

NOTE: If the HCFA-441 instructions are not issued prior to January 1, 1985, that report is not to be included in this factor's evaluation.

1. Review all HCFA-441 reports, all HCFA-420 reports, the HCFA-2082 and the HCFA-350 received during the fiscal year. Reports used for measurement of timeliness in 5I1, 5I2, and 5I3 are the reports which must be used to gauge accuracy.

2. Check for completion, consistency, and surface accuracy. It should be recognized that reports completion will vary from State to State because of variations in State operations. Some care should be taken in reviewing reports to insure that deficiencies such as missing report items, blank columns, etc., are in fact improper. A blank space is not automatically an error. Do not count as errors any elements which are linked to problems identified in the data validation review for Factor 5I4.

3. Use defined scoring as follows:

a. One (1) bonus point if no errors are found.

b. One-tenth (1/10) of a penalty point for each entry item deficiency. (An entry item deficiency would be a missing report item, an obvious computation error, a missing signature (if required, etc.))

c. One-half (1/2) of a penalty point for each missing or blank page of an individual report.

d. To calculate total penalty points sum all penalties and round in accordance with instructions. A maximum of six (6) penalty points may be accrued.

e. Weight is 1.

B. ELEMENT J.—THE STATE MUST UTILIZE THE CAPABILITIES OF MARS TO EFFECTIVELY MANAGE AND CONTROL THE MEDICAID PROGRAM AND PRODUCE REQUIRED REPORTS WHICH ARE ACCURATE, COMPLETE AND RECEIVED TIMELY.

Factor 5J1: The State must provide for on-going use of Management and Administrative Reports by State Management personnel.

Method of Evaluation

1. State Management and Administrative Reports must, at a minimum, contain information/statistical data to support the following objectives as indicated in the SMM, Chapter 3, §11340(A).

a. Fiscal planning and control.

b. Statistical data to be used in formulating Medical assistance policy and regulations.

c. Claims processing and payment activities.

d. Provider performance, participation, and service delivery.

e. Recipient participation and usage.

2. The State must demonstrate that Management and Administrative Reports are used in managing and controlling the Medicaid program. Such use can be demonstrated by written documentation, such as policy/procedure changes which result from analysis of State Management/statistical reports; by interviews with State Management staff which indicates familiarity with, and use of the reports in ongoing management activities, etc. It is considered a major problem if any one objective is not supported.

3. Use special scoring (see §11415.1). Weight is 1.5.

11420.6 STANDARD 6 - S/URS.-The Operation of a Surveillance and Utilization Review Subsystem (S/URS) Must Provide Comprehensive Health Care Delivery and Utilization Data for Program Management, Reveal Potential Defects in the Quality of Care, and Reveal Suspected Instances of Provider or Recipient Fraud or Abuse.

A. Element K.—AN APPROPRIATE ON-GOING REVIEW OF SERVICE DELIVERY AND UTILIZATION PATTERNS MUST BE MAINTAINED.

Factor 6K1: The State must periodically review, in an acceptable and timely manner, an established minimum of active recipients.

Method of Evaluation

1. The State must review each quarter at least .0001 (.01%-rounded to whole number) of the total body of active recipients (but not less than 15). Derive the number of active recipients to be reviewed from the Management Summary Report reflecting the summary field totals of recipients for the second previous quarter (e.g., for the July-September quarter, use the January-March quarter). At least 80% of the recipients to be reviewed must be selected from those identified through the ongoing quarterly exception process. Up to 20% of the minimum cases may be identified through other sources, but the information retrieval capabilities of the MMIS (e.g., exception profile, recipient history, etc.) must be used in support of these reviews.

2. A review is defined as sufficient analysis of the exceptions on the summary profile in order to resolve the exceptions and take appropriate followup action. A review must be initiated within 120 days after the summary profile is excepted. Credit the review for the quarter in which it is actually initiated rather than excepted or assigned. Active recipients are those who have incurred at least one (1) paid service during the review period, unless the State's definition is based on a higher number of incurred services.

3. Review State logs, etc., to assure that minimum review levels are met from each quarter's exceptions. If the State reviewed more than 25 cases in total for a quarter use the acceptance sampling technique described in §11410.1H to verify that the reviews are acceptable. To be acceptable cases must meet the criteria of items 2 and 4 of this method of evaluation. All cases sampled must be reviewed. If sampling is not used review all cases available.

4. Document that individual cases are manually analyzed and/or reviewed based on medical factors or medical and statistical factors as appropriate. Documentation must contain the following: 1) the reason(s) the recipient was reviewed (complaint and/or exceptions on the profile); 2) a chronological record of all analysis and review events, decisions made, and all actions taken to deal with the utilization problem, including who made the decisions and the reasons for taking the actions; 3) the information used to perform the review; 4) a record of all contacts with providers or beneficiaries, including interviews made in person or by telephone contact.

5. Use defined scoring as follows:

a. One (1) bonus point = Met minimum case review requirements, and all cases reviewed beyond the minimum requirement, or all of the cases sampled (when sampling was used) were acceptable.

b. Zero (0) = Met minimum case review requirements.

c. Three (3) penalty points = Did not meet minimum case review requirements.

d. Four (4) penalty points = Did not meet minimum case review requirements for two (2) consecutive years.

e. Five (5) penalty points = Did not meet minimum case review requirements for three (3) consecutive years.

f. Weight is 1.5.

Factor 6K2: The State must periodically review, in an acceptable and timely manner, an established minimum of active non-Inpatient Hospital Services (non-IHS) providers.

Method of Evaluation

1. A review is defined as sufficient analysis of the exceptions on the summary profile in order to resolve the exceptions and take appropriate followup action. A review must be initiated within 120 days after the summary profile is excepted. Credit the review for the quarter in which it is actually initiated rather than excepted or assigned. Active providers are those who have provided at least one (1) adjudicated Medicaid service during the review period, unless the State definition is based on a greater number of services.

2. The definitions of types of services, which appear in the instructions to State Agencies for completion of the Federal reports, are used for determining the groupings of provider types. The instructions are located in Part 2 of the SMM, Chapter 2, §2700.2.

3. The State must review each quarter at least .005 (.5%) (but not less than ten (10)) of the total body of a quarter's active non-institutional providers of each of the following service type groupings:

a. Physicians' Services and Clinic Services

b. Prescribed Drugs

c. All others.

Derive the number of providers to be reviewed from the Management Summary Report reflecting the summary field totals of providers for the second previous quarter (e.g., for the July-September quarter, use the January-March quarter).

States that elect to conduct focused reviews do not have to review every class/peer group of every category of service, or even all minor categories of service quarterly. However, when selective analysis and reporting of this kind is done every report category of service and class group must be run at least once within the first three quarters (due June 30) to assure completeness.

4. At least 80% of the non-IHS providers to be reviewed must be selected from those identified through the ongoing exception process. Up to 20% of the minimum cases may be identified through other sources, but the information retrieval capabilities of the MMIS (e.g., exception profile, provider history, etc.) must be used in support of these reviews.

5. Review State logs, etc., to assure that minimum review levels were met and identify cases for documentation reviews. For non-IHS providers if the State reviewed more than 25 cases per provider type per quarter use the acceptance sampling technique described in §11410ff to verify that the reviews are acceptable. All cases sampled must be reviewed. If sampling is not used review all cases available. To be acceptable cases must meet the criteria of items 1 and 6 of this method of evaluation.

6. The State must document that individual cases are manually analyzed and/or reviewed on the basis of medical factors or medical and statistical factors as appropriate. Documentation must contain the following: 1) the reason(s) the provider was reviewed (complaint and/or exceptions on the profile); 2) a chronological record of all actions taken to deal with the utilization problem, including who made the decisions and the reasons for taking the actions; 3) the information used to perform the review; 4) a record of all contacts with providers or beneficiaries, including interviews made in person or by telephone contact.

7. Use defined scoring as follows:

a. One (1) bonus point = Met minimum case review requirements for all categories and all cases reviewed beyond the minimum requirement or all of the cases sampled (when sampling is used) were acceptable for all quarters.

b. Zero (0) = Met minimum case review requirements.

c. Three (3) penalty points = Did not meet minimum case review requirements.

d. Four (4) penalty points = Did not meet minimum case review requirements for two (2) consecutive years.

e. Five (5) penalty points = Did not meet minimum case review requirements for three (3) consecutive years.

f. Weight is 2.

Factor 6K3: <u>The State must periodically review, in an acceptable and timely manner, an established minimum of active IHS providers.</u>

Method of Evaluation

1. A review is defined as sufficient analysis of the exceptions on the summary profile in order to resolve the exceptions and take appropriate followup action. A review must be initiated within 120 days after the summary profile is excepted. Credit the review for the quarter in which it is actually initiated rather than excepted or assigned. Active providers are those who have provided at least one (1) adjudicated Medicaid service during the review period, unless the State definition is based on a greater number of services.

2. The State must review annually a number of IHS providers as follows:

a. The following States must review at least 25 IHS providers:

(1) California
(2) Texas
(3) New York

b. The following States must review at least 20 IHS providers:

(1) Pennsylvania
(2) Illinois
(3) Florida
(4) Ohio
(5) Michigan

c. The following States must review at least 15 IHS providers:

(1) Minnesota
(2) Georgia
(3) Missouri
(4) Tennessee
(5) North Carolina
(6) Wisconsin
(7) Kansas
(8) Louisiana
(9) Oklahoma
(10) Indiana
(11) Alabama
(12) Iowa
(13) New Jersey
(14) Massachusetts

d. The following States must review at least 10 IHS providers:

(1) Virginia
(2) Mississippi
(3) Washington
(4) Kentucky
(5) Nebraska
(6) Arkansas
(7) Colorado
(8) Oregon
(9) South Carolina
(10) Maryland

e. The following States must review at least 5 IHS providers:

(1) West Virginia
(2) Montana
(3) South Dakota
(4) North Dakota
(5) Connecticut
(6) New Mexico
(7) Maine
(8) Idaho
(9) Utah

f. The following States must review at least 3 IHS providers:

(1) New Hampshire
(2) Hawaii
(3) Vermont
(4) District of Columbia

g. States not listed which receive approval for an MMIS during FY 1985 and are also subject to SPR must review at least 3 IHS providers.

3. At least 80% of the IHS providers to be reviewed must be selected from those identified through the ongoing exception process. Up to 20% of the minimum cases may be identified through other sources, but the information retrieval capabilities of the MMIS (e.g., exception profile, provider history, etc.) must be used in support of these reviews.

4. Review State logs, etc., to assure that minimum review levels were met and identify cases for documentation reviews. To be acceptable cases must meet the criteria of items 1 and 5 of this method of evaluation.

5. The State must document that individual cases are manually analyzed and/or reviewed on the basis of medical factors or medical and statistical factors as appropriate. Documentation must contain the following: 1) the reason(s) the provider was reviewed (complaint and/or exceptions on the profile); 2) a chronological record of all actions taken to deal with the utilization problem, including who made the decisions and the reasons for taking the actions; 3) the information used to perform the review; 4) a record of all contacts with providers or beneficiaries, including interviews made in person or by telephone contact.

6. In States that have a contract with Peer Review Organizations (PRO) to conduct hospital reviews, case reviews will not be required for the claim type covered in their contract. However, States must document that they monitor the PRO's activities to assure that contractual obligations are being fulfilled.

7. Use defined scoring as follows:

a. Zero (0) = Met minimum case review requirements.

b. Three (3) penalty points = Did not meet minimum case review requirements.

c. Four (4) penalty points = Did not meet minimum case review requirements for two (2) consecutive years.

d. Five (5) penalty points = Did not meet minimum case review requirements for three (3) consecutive years.

e. Weight is 1.

Factor 6K4: The State must establish appropriate administrative mechanisms for resolving problems discovered through S/URS reviews and periodically evaluate the efficiency and effectiveness of such actions.

Method of Evaluation

1. Review documentation which confirms that the State is collecting and analyzing the results of actions taken on problems identified through S/URS.

2. The analysis should enable the State to measure program benefit savings. The analysis may include, but is not limited to, some of the following types of items:

*a. Dollars identified as overpayments through S/URS activities;

*b. Dollars identified through utilization screens as denials or payment reductions;

c. Number of cases referred for full scale fraud investigation;

d. Number of cases referred for field audit with medical record review;

e. Number of cases identified by S/URS;

f. Number of cases referred to S/URS from other sources.

g. Number of cases referred for other types of investigations.

3. Use special scoring (see §11415.1). Weight is 2.

*NOTE: Data reported on the HCFA-52 and HCFA-64 regarding overpayment recoveries may not necessarily correspond to the overpayments identified through State S/URS analysis.

THIS FACTOR IS SCORED AND REPORTED FOR MONITORING PURPOSES ONLY IN FY 1985. OMIT FACTOR SCORE FROM COLUMNS "k" - "o" ON THE STANDARD SCORING WORKSHEET.

Factor 6K5: The State must take actions befitting the analysis of individual cases identified through S/URS.

Method of Evaluation

1. Review a normal sample of provider cases identified by S/URS which were closed in the fiscal year. A case is defined to be, at a minimum, an integrity review. An integrity review is the initial process of investigating the aberrancies identified on the provider summary profile. (This process is a result of the quarterly preliminary screening and provider selection activity.)

The integrity review investigation entails obtaining additional data, e.g., provider detail, recipient history, and claims. The review will be closed after the investigation if it is determined that the aberrancies are not due to overutilization and can be explained; or that a pattern of overutilization or potential fraud warrants the initiation of a full scale investigation.

Verify that the investigation was appropriate to and focused on the aberrancies identified on the Summary Profile.

2. The case development and investigation based on S/URS Provider Summary Profiles should be guided by the procedures from the S/UR Operational Techniques Handbook (PB-216 158 dated April 1973). The S/UR Handbook should be used only as a guide and the State should not be held accountable for strict adherence to data configuration and procedural rules as illustrated.

3. The Acceptable Performance Level is 95 percent. Weight is 2. Use scoring chart D.

B. ELEMENT L.—THE STATE MUST PRODUCE SERVICE DELIVERY AND UTILIZATION DATA TIMELY AND ACCURATELY IN SUPPORT OF PROGRAM ADMINISTRATION.

Factor 6L1: S/URS Summary Profile Reports must be produced timely.

Method of Evaluation

1. Using production logs, verify run dates for all S/URS Summary Profile Reports. Normally all report runs must be included in the universe. However, if Summary Profile Reports for a particular category of service are run more frequently than once per quarter exclude from the universe any runs subsequent to the first for that service category.

2. For States which base their profile reports on adjudication dates, S/URS profiles must be produced not later than 45 calendar days after the close of the period reported. For States which base their profile reports on date of service, S/URS profiles must be produced not later than 90 calendar days after the close of the report period.

3. Use small universe scoring (chart F). Weight is 1.

Factor 6L2: The State must respond timely to user requests for profiles or reports.

Method of Evaluation

1. For purposes of this factor, profiles or reports are those within the specifications of the GSD; i.e., no special programming is required.

2. Select a normal sample of user requests for profiles or reports.

3. User requests for profiles or reports from current files should be met within 30 calendar days.

4. Verify timely production with such users; e.g., units responsible for EOB followup, fraud and abuse, etc.

5. Use of manual search and retrieval techniques in lieu of automated S/URS profiles or reports cannot be considered an acceptable alternative for purposes of this factor. States using such techniques are to be assessed six (6) penalty points.

6. The Acceptable Performance Level is 95 percent. Weight is 1. Use scoring chart D.

Factor 6L3: Recipient and provider profiles and reports must be produced.

Method of Evaluation

1. Verify that the State MMIS produces Management Summary and Summary Profile reports for all categories of services and recipient types (which represents the entire recipient and provider population) at least once during each review period. Each category of service, or recipient category must be generated at least as frequently as necessary to support 6K1 and 6K2 case review activity. Long Term Care Summary Profile and Management Profiles and IHS Summary Profiles (when PROs conduct IHS reviews) will not be reviewed.

2. Use defined scoring as follows:

a. Reports produced as required = 0
b. Each provider class group not produced = 1 penalty point
c. Each recipient class group not produced = 1 penalty point
d. No provider class group reports produced = 7 penalty points
e. No recipient class group reports produced = 6 penalty points
f. Accrue no more than seven (7) penalty points for provider reports and no more than six (6) penalty points for recipient reports.
g. Weight is 2.

Factor 6L4: Recipient Summary Profile Reports must contain required data and have internal consistency.

Method of Evaluation

1. Select a normal sample of excepted recipient summary profile reports or their demonstrable conceptual equivalents.

2. Review the selected reports and verify that they are complete, consistent and contain no obviously invalid data. Do not attempt to verify data contents per se. It should be recognized that the contents of reports will vary from State to State because of variations in State operations. Some care should be taken in reviewing reports to ensure that obvious deficiencies such as missing report items, blank columns, etc., are in fact improper. A blank space is not automatically an error.

3. Most S/URS have a zero suppress feature which would not produce data for an item when the value of the item is zero (0). For instance, for physicians, required items are counts of office visits and counts of surgical procedures. If a particular physician bills for office visits but not surgery, his report would indicate a value in office visits but there would be no line showing zero (0) surgical procedures. Consequently, to determine whether a system has all of the required items the S/URS control file must be checked to ensure that the required items were used for report production.

4. At a minimum, it is expected that the recipient summary profiles must use a total of at least 20 items reporting on receipt of services exclusive of those used for identification purposes. The following items must be included:

Identification Section

Class group
Name
Identification number
Location
Specialty

Services Summary Section

Dollars Paid - Medicaid
Number of Medical Visits
Payments for Medical Visits

Number of Surgical Procedures
Number of Outpatient Procedures
Number of Drug Prescriptions (RX)

5. Specific definitions for each item are established by the States. General definitions are available for information purposes in Section VI of the GSD.

6. Use defined scoring as follows:

a. One bonus point if no errors are found.

b. One-twentieth (1/20) of a penalty point for each entry item deficiency (e.g., a missing report item, an obvious computation error, etc.).

c. One fifth (1/5) of a penalty point for each missing or blank page of an individual report. A blank report is not acceptable for reviewing purposes.

d. To calculate total penalty points sum all penalty points and round in accordance with instructions. A maximum of four (4) penalty points may be accrued.

e. Weight is 1.

Factor 6L5: Provider summary profiles must contain required data and have internal consistency.

Method of Evaluation

1. Select a normal sample of provider summary profile reports or their demonstrable conceptual equivalents.

2. Review the selected reports and verify that they are complete, consistent and contain no obviously invalid data. Do not attempt to verify data contents per se. It should be recognized that reports completion will vary from State to State because of variations in State operations. Some care should be taken in reviewing reports to ensure that obvious deficiencies such as missing report items, blank columns, etc., are in fact improper. A blank space is not automatically an error. States which contract with a PRO to conduct hospital reviews will not be reviewed for accuracy of hospital summary profiles.

3. Most S/URS have a zero suppress feature which would not produce data for an item when the value of the item is zero (0). For instance, for physicians, required items are counts of office visits and counts of surgical procedures. If a particular physician bills for office visits but not surgery, his report would indicate a value in office visits but there would be no line showing zero (0) surgical procedures. Consequently, to determine whether a system has all of the required items the S/URS control file must be checked to ensure that the required items were used for report production.

4. At a minimum, summary profiles must use a total of 20 report items (in addition to those items used for identification purposes) for the following provider types: physician services, inpatient hospital services, dental services, and prescribed drugs. All other provider types must use a minimum of at least ten (10) items. The following items must be included for the provider types indicated:

PHYSICIAN SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Medical Visits
Location	Average Number of Visits/Recipient
Speciality	Number of Surgical Procedures
	Payments for Surgery
	Number of Diagnostic Radiology Procedures
	Payments for Diagnostic Radiology Procedures
	Number of Diagnostic Laboratory Procedures
	Payments for Diagnostic Laboratory Procedures

INPATIENT HOSPITAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Discharges
Location	Average Stay/Discharge
	Percent Discharges 1 Day
	Percent Discharges 2 Days

OUTPATIENT HOSPITAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Services Provided
Location	Average Number of Services/Recipient
	Average Payment/Service

DENTAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Services Provided
Location	Average Number of Services/Recipient
	Average Payment/Service

PRESCRIBED DRUGS

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Prescriptions Filled
Location	Average Number of Prescriptions/Recipient
	Average Payment/Prescription

ALL OTHERS

Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
Name	Average Payment/Recipient
Number	Number of Services Provided
Location	Average Number of Services/Recipient
	Average Payment/Service

5. Specific definitions for each item are established by the States. General definitions are available for information purposes in Section VI of the GSD.

6. Use defined scoring as follows:

a. One bonus point if no errors are found.

b. One-twentieth (1/20) of a penalty point for each entry item deficiency (e.g., a missing report item, an obvious computation error, etc.).

c. One fifth (1/5) of a penalty point for each missing or blank page of an individual report. A blank report is not acceptable for reviewing purposes.

d. To calculate total penalty points sum all penalty points and round in accordance with instructions. A maximum of four (4) penalty points may be accrued.

e. Weight is 1.

Factor 6L6: Management Summary Reports must contain required data and have internal consistency.

Method of Evaluation

1. Select a normal sample of Management Summary Reports or their demonstrable conceptual equivalents.

2. Review the selected reports and verify that they are complete, consistent and contain no obviously invalid data. To verify consistency other S/URS cyclical report outputs may be requested. Do not attempt to verify data contents *per se*. It should be

recognized that reports completion will vary from State to State because of variations in State operations. Some care should be taken in reviewing reports to ensure that obvious deficiencies such as missing report items, blank columns, etc., are in fact improper. A blank space is not automatically an error. States which contract with a PRO to conduct hospital reviews are required to produce hospital Management Summary Reports.

3. Most S/URS have a zero suppress feature which would not produce data for an item when the value of the item is zero (0). For instance, for physicians, required items are counts of office visits and counts of surgical procedures. If a particular physician bills for office visits but not surgery, his report would indicate a value in office visits but there would be no line showing zero (0) surgical procedures. Consequently, to determine whether a system has all of the required items the S/URS control file must be checked to ensure that the required items were used for report production.

4. At a minimum, management summary reports must use a total of 20 report items (in addition to those items used for identification purposes) for recipients and the following provider types: physician services, inpatient hospital services, outpatient hospital services, dental services, and prescribed drugs. All other provider types must use a minimum of at least 10 items. The following items must be included for the following categories:

RECIPIENT

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Medical Visits
	Payments for Medical Visits
	Number of Surgical Procedures
	Number of Outpatient Services
	Number of Drug Prescriptions (RX)

PHYSICIAN SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
	Average Payment/Recipient
	Number of Medical Visits
	Average Number of Visits/Recipient
	Number of Surgical Procedures
	Payments for Surgery
	Number of Diagnostic Radiology Procedures
	Payments for Diagnostic Radiology Procedures
	Number of Diagnostic Laboratory Procedures
	Payments for Diagnostic Laboratory Procedures

INPATIENT HOSPITAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
	Average Payment/Recipient
	Number of Discharges
	Average Stay/Discharge
	Percent Discharges 1 Day
	Percent Discharges 2 Days

OUTPATIENT HOSPITAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
	Average Payment/Recipient
	Number of Services Provided
	Average Number of Services/Recipient
	Average Payment/Service

DENTAL SERVICES

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
	Average Payment/Recipient
	Number of Services Provided
	Average Number of Services/Recipient
	Average Payment/Service

PRESCRIBED DRUGS

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
	Average Payment/Recipient
	Number of Prescriptions Filled
	Average Number of Prescriptions/Recipient
	Average Payment/Prescription

ALL OTHERS

Identification Section	Volume Summary Section
Category of Service	Dollars Paid-Medicaid
Class Group	Number of Recipients Served-Medicaid
	Average Payment/Recipient
	Number of Services Provided
	Average Number of Services/Recipient
	Average Payment/Service

5. Specific definitions for each item are established by the States. General definitions are available for information purposes in Section VI of the GSD.

6. Use defined scoring as follows:

a. One bonus point if no errors are found.

b. One-twentieth (1/20) of a penalty point for each entry item deficiency (e.g., a missing report item, an obvious computation error, etc.).

c. One-fifth (1/5) of a penalty point for each missing or blank page of an individual report. A blank report is not acceptable for review purposes.

d. To calculate total penalty points sum all penalties and round in accordance with instructions. A maximum of four (4) penalty points may be accrued.

e. Weight is 1.

C. ELEMENT M.—THE CAPABILITIES OF S/URS MUST BE UTILIZED TO AID IN PROGRAM MANAGEMENT AND SYSTEM IMPROVEMENT.

Factor 6M1: S/URS Management Summary Reports must be used in program evaluation and planning.

Method of Evaluation

1. Verify the distribution of S/URS Management Summary Reports.

2. The State is to document the use of the information from the reports. Such use can be shown by State familiarity with the information, and by written documentation such as inter-office memoranda and minutes of meetings which addressed S/URS analysis.

3. Use special scoring (see §11415.1). Weight is 1.5.

Factor 6M2: Exception criteria must be adjusted to meet program needs.

Method of Evaluation

1. The exception criteria must be routinely updated to identify potential misuse or abuse.

2. Utilizing at least six (6) months data, analyze changes made to the exception criteria during the review period and review the methodology used to select report items, classify recipients into class groupings and providers into peer groups, and establish group norms and exception limits.

3. The factor is not deemed met if no changes were made during the review period. However, regional offices must document that such inactivity was appropriate or inappropriate .

4. Use special scoring (see §11415.1). Weight is 2.

Factor 6M3: The State must establish and use S/URS related feedback mechanisms for improving system performance.

Method of Evaluation

1. The State must establish and use a feedback mechanism from all users of S/URS outputs and derived data to S/URS staff responsible for defining and controlling those parameters relating to recipient class groupings, provider peer groups, report item definition and exception criteria.

2. The State must establish and use a feedback mechanism from S/URS staff to other MMIS staff so as to capitalize on S/UR experience and data in the definition and refinement of claims processing edits, procedures and program policy changes.

3. Verify that the State has established the feedback mechanisms required above. The State must also provide documentation that the mechanisms are used to provide information to assess the need for system, program and procedural changes. Further, the State must provide documentation of actions taken on the basis of such feedback, although it cannot be expected that all information exchanged will result in changes.

4. Use special scoring (see §11415.1). Weight is 1.

11420.7 STANDARD 7 - MMIS ADMINISTRATION.—Overall Effectiveness in Carrying Out MMIS Administrative Responsibilities Must Be Demonstrated.

A. ELEMENT N.—PRUDENT AND EFFECTIVE SYSTEM MANAGEMENT MUST BE PROVIDED.

Factor 7N1: Effective monitoring of fiscal agents and contractors must be demonstrated.

Method of Evaluation

1. In States where a fiscal agent/contractor is used, the State agency must maintain an effective, ongoing program for monitoring the fiscal agent or contractor services. Other governmental agencies outside the Single State Agency that furnish claims processing or information retrieval support are included under the definition of fiscal agents/contractors. If the Single State Agency does not utilize a fiscal agent or contractor, the factor is deemed met.

2. Verify that the State data processing facility has an approved service agreement (when data processing services are to be provided by a State central data processing facility or by another State or local agency) with the Single State Agency per 45 CFR 95.611(b)(2). Contracts for data entry are excluded from review for this factor.

3. Following are examples of documents that reflect effective State oversight: minutes of meetings between fiscal agent/contractor and State agency representatives; policy issuances and correspondence between the fiscal agent/contractor and the State agency. Reports of State agency evaluation of performance should also be reviewed.

4. Review the State control system for requests to, and deliverables from, the fiscal agent.

5. This review should indicate that the State agency did provide direction and guidance to the fiscal agent and has effectively monitored the contractor's performance against the provisions of the respective contracts. Such monitoring includes: appropriate use of contract options; assessment where permitted of liquidated damages; nonrenewals; etc.

6. Use special scoring (see §11415.1). Weight is 2.

Factor 7N2: The State must have available a current/updated set of program and system documentation.

Method of Evaluation

1. Review documentation including those areas of the system that are user parameter driven for completeness. This should include all necessary data to support the system operation, maintenance, data control, back-up, etc.

2. Review the documentation updating procedures. Updates should be timely, complete and logged in.

3. Review the State's procedures of controls on how parameters are changed, added or deleted. Check logs, computer reports, etc., for the correctness of changes. Also review the supporting documentation showing reasons for the changes. (Exclude review areas in 6M2.)

4. The documentation should meet State standards as of the time it was created or, in the absence of State standards, be conceptually equivalent to the Federal Information Processing Standards.

5. Use special scoring (see §11415.1). Weight is 1.

Factor 7N3: The State must have written provider agreements which hold the providers responsible for all EMC data submitted to a State or fiscal agent.

Method of Evaluation

1. Determine if agreements exist for providers who submit via EMC.

2. The agreements should adequately protect the integrity of the claim process. Some examples of content are:

a. signature requirements
b. access to source documents
c. source document retention
d. audit conventions
e. EMC submittal procedures
f. EMC record layouts
g. Privacy Act requirements
h. service verification
i. provider certification

3. Provider responsibility could be demonstrated via the following examples:

a. Various provisions within the provider agreement
b. Memoranda of Understanding between States and providers
c. Service agreement between the provider and service bureau

4. Use special scoring (see §11415.1). Weight is 1.

Factor 7N4: The State must exercise effective internal quality control (QC) of claims processing and payment through its approved claims processing assessment system (CPAS).

Method of Evaluation

NOTE: This item will not be scored in FY 1985 unless the CPAS regulation is published on or before January 2, 1985.

1. Determine that the State is operating a CPAS that conforms with the system approved by HCFA.

2. Determine if minimum error conditions are addressed and reflected for States where a mandated system is required or the State has elected to use the mandated system. Use the guidelines in the draft SMM, Part 7, Quality Control, to evaluate this factor.

3. Use special scoring (see §11415.1). Weight is 1.

Factor 7N5: The State must take corrective action on problems identified through CPAS.

Method of Evaluation

1. Review the States' most recently approved CPAS corrective action plan. The plan must address claims processing deficiencies identified through the CPAS operation.

2. The State must have made reasonable progress in the application of the corrective action plan. Reasonable progress should be determined based on the nature of the problems to be corrected and the schedule for correction as outlined in the plan.

THIS FACTOR IS SCORED AND REPORTED FOR MONITORING PURPOSES ONLY IN FY 1985. OMIT FACTOR SCORE FROM COLUMNS "k" - "o" ON THE STANDARD SCORING SHEET.

B. ELEMENT O.—ADEQUATE INTERNAL SYSTEM INTEGRITY AND SAFEGUARDS FOR INFORMATION ON RECIPIENTS SHOULD BE ASSURED.

Factor 701: Appropriate administrative, technical and physical system integrity safeguards should be established and utilized.

Method of Evaluation

1. Verify the existence of safeguards designed to assure the integrity of system hardware, software, records and files. Examples of such safeguards may include:

Administrative

a. Orienting new employees to security policies and procedures.

b. Conducting periodic review sessions on security procedures, including significant changes.

c. Developing listings of personnel to be contacted in the event of a security breach.

d. Maintaining entry logs for limited access areas.

e. Maintaining an inventory of State controlled MMIS assets. (This does not include any financial assets.)

f. Performing a periodic risk analysis, a systematic method for anticipating mishaps and determining the cost-effectiveness of safeguards.

Physical

a. Limiting physical access to systems hardware.

b. Maintaining confidential and critical materials in limited access, secured areas.

Technical

a. Establishing a hierarchy of system access codes with system monitoring and reporting of attempted unauthorized use of codes.

b. Requiring multiple authorizations for program and file changes.

2. Interview appropriate staff to determine if established safeguards are utilized.

3. Manual citation: Part 11 of the SMM, Chapter 3, §11300(B)4.

4. Use special scoring (see §11415.1). Weight is 1.5.

Factor 702: The State must establish appropriate criteria for safeguarding and disclosing Medicaid information.

Method of Evaluation

1. Review State criteria and procedures for safeguarding and disclosing recipient and claims information. These criteria/procedures must meet the requirements of Federal regulations. Verify that these procedures are actually used.

2. Regulation citations: Safeguarding of Information - 42 CFR 431.301, 431.305, Release of Information - 42 CFR 431.306.

3. Use special scoring (see §11415.1). Weight is 1.

Factor 703: Written recovery and backup procedures to prevent extended disruption of services in emergency situations must be established.

Method of Evaluation

1. Verify that the State maintains, and is reasonably capable of implementing, an established written procedure to handle emergency situations. The procedure should contain a contingency plan to deal with emergencies and provide documentation on the method of recovery of operating systems software. A State's capability is assessed in terms of control over people, facilities, equipment and money.

2. Responsible staff must be knowledgeable in the method of implementation of such procedures.

3. Review the State contingency plan in dealing with systems software, system libraries and critical data sets along with master files. Verify that these materials are duplicated and stored at an off-site facility.

4. Use special scoring (see §11415.1). Weight is 1.5.

11420.8 STANDARD X - AUTOMATED ELIGIBILITY DETERMINATION AND INFORMATION RETRIEVAL SYSTEMS.—Automated Eligibility Determinations Must Be Made in an Efficient and Effective Manner.

This standard has been developed to measure the performance of approved Medicaid eligibility determination systems which are receiving enhanced funding from the Health Care Financing Administration. The review is being conducted in FY 1985 as a dry run to further develop a systems performance data base. Consequently, the results of the review will not affect the enhanced matching funds for Medicaid Management Information System (MMIS) operations. This performance standard cannot affect such funding until it is promulgated in the Federal Register.

A. ELEMENT 1.—INTAKE PROCEDURES MUST BE ACCURATE AND TIMELY.

Factor X1a: An eligibility determination/calculation must be made in a timely manner.

Method of Evaluation

1. Select an automated intermediate low sample of recipient eligibility applications filed within the current review period. Request a photocopy of the complete hard copy recipient case file. The State must submit these photocopies to the regional office within 45 days of the request. At the same time the hard copy file is being requested secure a copy of all information which is available in the automated eligibility determination system for the sample cases.

2. Compare the application dates and the resolution dates for each individual case. The resolution date is the date all information necessary in making an eligibility determination/calculation is available in the automated eligibility system and the determination/calculation is processed through the system. All eligibility determinations/calculations must be made within 45 days of the application. Measure the time elapsed beginning with the day the application was filed through the date of resolution.

3. The agency must determine eligibility within these stated periods except in unusual circumstances; e.g., when a decision cannot be reached because the applicant, or a provider delays or fails to take a required action, or there is an administrative emergency beyond the State's control. The reason for the delay must be fully documented in the case folder.

4. Regulatory citation: 42 CFR 435.911.

5. The Acceptable Performance Level is 97.5 percent. Weight is 1.5. Use scoring chart C.

Factor X1b: Accurate eligibility data must be recorded on the MMIS.

Method of Evaluation

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Compare the information from the hard copy case folder to the system generated eligibility information. The following data elements, as required by the SMM, Part 15, Chapter 4, must be posted accurately: 1.01-1.05, 1.07, 1.09-1.12, 1.20-1.24, 1.27, 1.29-1.31, 1.36, 1.41-1.46, 1.71-1.73, 2.01, 2.03, 2.31, 2.34, 2.41, 2.44, 3.01, 3.22, 3.60, 4.01, 5.00, 6.01, 6.03-6.05, 7.03. Only count one (1) error per case.

3. The Acceptable Performance Level is 97.5 percent. Weight is 2. Use scoring chart C.

Factor X1c: Eligibility data must be verified by the State in accordance with established policies/procedures.

Method of Evaluation

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Review State procedures to determine the data which must be verified for eligibility.

3. Check the case folders to determine if the data fields reviewed in factor X1b have been verified as required by the State. Count unverified data as an error unless verification is pending. Count only one (1) error per case.

4. The Acceptable Performance Level is 97.5 percent. Weight is 1.5. Use scoring chart C.

Factor X1d. A unique identifier must be assigned to each Medicaid recipient.

Method of Evaluation

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Check the sample against information available in the MMIS for duplicate names, social security numbers, recipient identification numbers, date of birth, sex, and address. To accomplish this obtain the name, date of birth, sex, and address of each recipient in the sample. Then query the system to determine if any of these data match that of other recipients in the automated eligibility determination subsystem. Count only one (1) error per case.

3. The Acceptable Performance Level is 99 percent. Weight is 1.5. Use scoring chart C.

B. ELEMENT 2.—THE CASE MANAGEMENT SYSTEM MUST SUPPORT PROGRAM OBJECTIVES.

Factor X2a: A redetermination date must be accurately established for each eligibility case.

Method of Evaluation

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Review State procedures to determine when redeterminations must be scheduled for each category of recipient eligibility. Use the recipient history to determine if the redetermination date has been accurately posted. The reviewer should take into consideration an operation which could be considered a demonstrable conceptual equivalent to the posting of a redetermination date; e.g., monthly runs matching last redetermination date to current operating month to determine who on the entire file is subject to a redetermination for the current month.

3. Regulatory Citation: 42 CFR 435.916.

4. The Acceptable Performance Level is 97.5 percent. Weight is 1.5. Use scoring chart C.

Factor X2b: The system must be utilized to determine type and extent of benefits available to an individual.

Method of Evaluation

1. Use the intermediate low sample of eligibility cases from factor X1a.

2. Review State procedures to determine proper eligibility criteria. Determine if each case was processed through the system to calculate type and extent of benefits. Information in the case folder to verify performance may include, but is not limited to, some of the following: automated data input documents indicating raw data necessary to make eligibility calculation; printouts in file indicating automated calculation; or handwritten manual calculations which indicate the lack of automated calculation.

3. The Acceptable Performance Level is 97.5 percent. Weight is 2. Use scoring chart C.

Factor X2c: The State must utilize the information retrieval capabilities of the automated eligibility determination system in the operation of the Medicaid program.

Method of Evaluation

1. Verify that the system generates management reports on a periodic or on demand basis. These reports include but are not limited to pending case reports, aged case reports, redetermination due reports, purged case reports, social security number enumeration reports, and error reports.

2. The State must demonstrate through documentation and interviews that eligibility management reports are used. The reports must be produced as required by State procedure and used to accomplish program goals.

3. Use special scoring (see §11415.1). Weight is 1.

APPENDIX A

(Scoring Worksheets)

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 1 Recipient Eligibility	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
A		Accurate Elig Determinations																
	1	Eligibility Data Requirements			Special						2							
		Element A Total										50						
B		Accurate and Adequate Elig Files																
	1	Integrate SSI Data Timely			Normal Smpl			95%			1							
	2	Timely Elig Status Changes			Defined						1							
	3	Timely Buy-In Updates			Defined						1							
	4	Accurate Buy-In Updates			Normal Smpl			95%			1.5							
		Element B Total										50						
		STANDARD 1 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 2 Support Files	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
C		Accurate Provider Files																
	1	Timely Provider Status Updates			Norm Smpl			99%			1							
	2	Maintain Accurate Provider Files			Norm Smpl			99%			1.5							
	3	Provide Unique Ident Individual			Norm Smpl			99%			1.5							
	4	Assign Unique Identifier Group			Norm Smpl			99%			2							
		Element C Total										50						
D		Accurate Pricing Files																
	1	Timely Pricing File Updates			Norm Smpl			95%			1.5							
	2	Accurate Pricing File Updates			Norm Smpl			99%			1							
		Element D Total										50						
		STANDARD 2 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 3 Orderly & Timely Claims Processing	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
E		Claims Control																
	1	Unique Ident & Proper Aging			Exp Smpl			99%			2							
	2	Timely Control of EMCs			Special						1							
	3	Unique Ident & Aging EMCs**			Norm Smpl			99%			1							
	4	Timely & Complete EOBs			Norm Smpl			99%			1.5							
		Element E Total										50						
F		Timeliness of Claims Processing																
	1	Practitioner Clean Claims-30 Days			Norm Inter Exp Smpl			90%			2							
	2	Practitioner Clean Claims-90 Days			Norm Inter Exp Smpl			99%			2							
	3	Other Claims - 30 Days			Norm Inter Exp Smpl			99%			1							
	4	All Claims - 12 Months			Norm Inter Exp Smpl			99%			1							
		Element F Total										50						
		STANDARD 3 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

**Not Considered in Element Score in FY 85

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 4 Accurate Payment and Review	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right / $ Error Rate	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
G		Processing Accuracy																
	1	Clms Must Be Processed Accurately			Fixed Smpl			97.5%			3							
	2	Claims Must be Paid Accurately**			$ Error Rt													
		Element G Total										50						
H		Edits and Screens																
	1	Consistency & Util Edits/Screens			Special						1.5							
	2	Duplicate Claim Resolution			Norm Smpl			95%			1.5							
	3	Control Use of Force Codes			Norm Smpl			99%			1.5							
		Element H Total										50						
		STANDARD 4 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

**Will Determine Which CPAS A State Must Operate in FY 86

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 5 MARS	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
I		Federal Reports																
	1	Timely HCFA-441 & HCFA-420			Defined						2							
	2	Timely HCFA-2082			Defined						2							
	3	Timely HCFA-350			Defined						1							
	4	Valid Statistical Data			Defined						1.5							
	5	Accurate HCFA Reports			Defined						1							
		Element I Total										50						
J		State Reporting & Mgmt Control																
	1	MARS Utilization			Defined						1.5							
		Element J Total										50						
		STANDARD 5 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 6 S/URS	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
K		Service Delivery & Utilization																
	1	Recipient Review			Defined						1.5							
	2	Provider Review (Non-IHS)			Defined						2							
	3	Provider Review (IHS)			Defined						1							
	4	Estab Follow-Up/Eval Procedures**			Special						2							
	5	Take Proper Action on Cases			Norm Smpl			95%			2							
		Element K Total										50						
L		Data to Support Program Admin																
	1	Produce Timely S/URS Profiles			Sml Univ						1							
	2	Respond Timely to User Requests			Norm Smpl			95%			1							
	3	Produce Profiles & Reports			Defined						2							
	4	Required Recipient Summary Data			Defined						1							
	5	Required Provider Summary Data			Defined						1							
	6	Required Management Summary Data			Defined						1							
		Element L Total										50						
M		S/URS Program Management																
	1	Use S/URS in Program Management			Special						1.5							
	2	Adjust Exception Criteria			Special						2							
	3	Use Feedback Mechanisms			Special						1							
		Element M Total										50						
		STANDARD 6 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

**Not Considered in Element Score in FY 85

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard 7 System Administration	a Date Review Ended Mo.	Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
N		Systems Management																
	1	Effective Monitoring Fiscal Agent			Special						2							
	2	Program & System Documentation			Special						1							
	3	EMC Billing Svc Agreements			Special						1							
	4	Quality Control Through CPAS			Special						1							
	5	Corrective Action Through CPAS**																
		Element N Total										50						
O		Integrity and Safeguards																
	1	Estab & Use Sys Integ Safeguards			Special						1.5							
	2	Estab Medicaid Info Safeguards			Special						1							
	3	Written Recovery & Backup Proced			Special						1.5							
		Element O Total										50						
		STANDARD 7 TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

**Not Scored in FY 85

STATE _____ REGION _____

SYSTEM PERFORMANCE REVIEW WORKSHEET

ELEMENT	FACTOR	Standard X MEDIRS	a Date Review Ended Mo.	a Date Review Ended Yr.	b Scoring Technique	c Universe Size	d Annual Sample Size	e Apl	f % Right	g Number of Errors	h Wt.	i Starting Score	j Penalty Points	k Actual Penalty Amount h X j	l Initial Score i-k	m Bonus Points	n Actual Bonus Amount h X m	o Final Score l(+n*)
1		Accurate/Timely Intake Procedures																
	a	Timely Elig Determination/Calc			Inter Low Smpl			97.5%			1.5							
	b	Record Eligibility Data			Inter Low Smpl			97.5%			2							
	c	Verify Eligibility Data			Inter Low Smpl			97.5%			1.5							
	d	Unique Identifier Assigned			Inter Low Smpl			99%			1.5							
		Element 1 Total										50						
2		Case Management System																
	a	Estab Accurate Redet Date			Inter Low Smpl			97.5%			1.5							
	b	Auto Eligibility Determination			Inter Low Smpl			97.5%			2							
	c	Info Retrieval Utilization			Special						1							
		Element 2 Total										50						
		STANDARD X TOTAL																

*Bonus points can be added if initial score equals or exceeds 44.

MARS WORKSHEET FY 85
PREVIOUSLY REVIEWED SYSTEM

STATE REGION

	FY85 REPORTS	OCT	JAN	APR	JUL	BONUS POINTS	TOT DAYS LATE 1/	PENALTY POINTS
HCFA 420	REPORT FOR	JUL-SEP	OCT-DEC	JAN-MAR	APR-JUN			
	DUE DATE	10/30/84	1/30/85	04/30/85	07/30/85			
	DATE RECEIVED							
	DAYS LATE 1/							
HCFA 441	REPORT FOR		OCT-DEC	JAN-MAR	APR-JUN			
	DUE DATE		1/31/84	04/30/85	07/31/85			
	DATE RECEIVED							
	DAYS LATE 1/							
						2/	4/	4/
HCFA 2082	REPORT FOR		FY 84					
	DUE DATE		01/15/85					
	DATE RECEIVED					3/		
	DAYS LATE 1/							5/
HCFA 350	REPORT FOR			FY 84				
	DUE DATE			4/15/85				
	DATE RECEIVED					6/		
	DAYS LATE 1/							7/

1/ INDICATE IN THE TOP HALF OF THE BLOCK THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

2/ ONE BONUS POINT IF ALL 7 REPORTS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 511 ON THE SPR SCORING WORKSHEET.

3/ TWO BONUS POINTS IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 512 ON THE SPR SCORING WORKSHEET.

4/ SUM OF DAYS LATE DIVIDED BY 7 AND ROUND TO ONE DECIMAL POINT (DO NOTE EXCEED 6). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 511 ON THE SPR SCORING WORKSHEET.

5/ SUM OF DAYS LATE DIVIDED BY 5 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 6.) THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 512 ON THE SPR SCORING WORKSHEET.

6/ ONE BONUS POINT IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 513 ON THE SPR SCORING WORKSHEET.

7/ SUM OF DAYS LATE DIVIDED BY 7 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 3). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 513 ON THE SPR SCORING WORKSHEET.

8/ INDICATE IN THE TOP HALF OF THE BLOCK THE SUM OF THE COLUMNS WHICH REPRESENTS THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE SUM OF THE COLUMNS WHICH REPRESENTS THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

MARS WORKSHEET FY 85
SYSTEM FIRST SUBJECT TO SPR

STATE REGION

	FY85 REPORTS	OCT	JAN	APR	JUL	BONUS POINTS	TOT DAYS LATE 1/	PENALTY POINTS
HCFA 420	REPORT FOR	JUL-SEP	OCT-DEC	JAN-MAR	APR-JUN			
	DUE DATE	10/30/84	1/30/85	04/30/85	07/30/85			
	DATE RECEIVED							
	DAYS LATE 1/							
HCFA 441	REPORT FOR		OCT-DEC	JAN-MAR	APR-JUN			
	DUE DATE		1/31/84	04/30/85	07/31/85			
	DATE RECEIVED							
	DAYS LATE 1/							
						2/	8/	4/
HCFA 2082	REPORT FOR		FY 84					
	DUE DATE		01/15/85					
	DATE RECEIVED					3/		
	DAYS LATE 1/							5/
HCFA 350	REPORT FOR			FY 84				
	DUE DATE			4/15/85				
	DATE RECEIVED					6/		
	DAYS LATE 1/							7/

1/ INDICATE IN THE TOP HALF OF THE BLOCK THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

2/ ONE BONUS POINT IF ALL 7 REPORTS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 5H ON THE SPR SCORING WORKSHEET.

3/ TWO BONUS POINTS IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 5H2 ON THE SPR SCORING WORKSHEET.

4/ FOR NEW SYSTEMS SUM OF DAYS LATE FOR REPORTS DUE IN THE FIRST 6 MONTHS DIVIDED BY 50 AND ROUND TO ONE DECIMAL POINT; PLUS THE SUM OF DAYS LATE FOR SUBSEQUENT REPORTS DIVIDED BY SEVEN AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 6). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 5H ON THE SPR SCORING WORKSHEET.

5/ FOR NEW SYSTEMS SUM OF DAYS LATE DIVIDED BY 20 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 6). THIS FIGURE IS TO BE ENTERED IN COLUMN J FOR FACTOR 5H2 ON THE SPR SCORING WORKSHEET.

6/ ONE BONUS POINT IF THE REPORT IS RECEIVED BEFORE THE DUE DATE. THIS FIGURE IS TO BE ENTERED IN COLUMN M FOR FACTOR 5B ON THE SPR SCORING WORKSHEET.

7/ FOR NEW SYSTEMS SUM OF DAYS LATE DIVIDED BY 28 AND ROUND TO ONE DECIMAL POINT (DO NOT EXCEED 3). TO BE ENTERED IN COLUMN J FOR FACTOR 5B ON THE SPR SCORING WORKSHEET.

8/ INDICATE IN THE TOP HALF OF THE BLOCK THE SUM OF THE COLUMNS WHICH REPRESENTS THE ABSOLUTE NUMBER OF DAYS THE REPORT IS LATE. INDICATE IN THE BOTTOM HALF THE SUM OF THE COLUMNS WHICH REPRESENTS THE NUMBER OF DAYS THE REPORT IS LATE MINUS THE FIVE WORKING DAYS TOLERANCE.

S/URS WORKSHEET

INSTRUCTIONS FOR COMPLETION

HEADER ITEMS

FACTOR -	Enter the number of the factor being reviewed.
STATE -	Enter the name of the State.
TOTAL FROM MGMT SUM REPORT (2ND PREVIOUS QTR) -	Enter the total number of recipients or noninstitutional providers from the Management Summary Report. This number is used to compute the number of reviews required.
REQUIRED REVIEWS -	Multiply the number of recipients by the decimal fraction provided in the MOE to compute the number of reviews required. Enter that number.
NUMBER OF CASES REVIEWED -	Exception processing - Enter the number of cases as indicated by the State's control log on the first page of series only.
NUMBER OF CASES REVIEWED -	Other Sources - Enter the number of cases as indicated by the State's control log on the first page of series only.
QUARTER UNDER REVIEW -	Indicate which quarter the listed cases will be credited.

REFERENCE NUMBER

(1) NAME - ID NUMBER	Enter the name and identification number of the recipient or provider.
(2) EXCEPT - (3) and REF	Enter a check mark to indicate whether the case was excepted or referred.
(4) DATE OF EXCEPTION RUN OR REFERRAL -	Enter the date of the exception or the date the referral was received by the S/UR unit.

(5)	DATE CASE ASSIGNED -	Enter the date the case was assigned for review.
(6)	DATE REVIEW INITIATED -	Enter the date the review was initiated as indicated in the case file documentation. This date is to be used to determine the quarter when the claim will be counted. Use this date in connection with the date of the exception to determine if the review began within 120 days after the exception.
(7)	STATISTICAL AND MEDICAL ANALYSIS -	Indicate by yes or no whether the file indicates a statistical and medical analysis.
(8)	ISSUES ADDRESSED -	Indicate by yes or no whether the issues raised by the exception report or referral were addressed.
(9)	CHRONOLOGICAL RECORD -	Indicate by yes or no whether the file contains the chronological record of the case development as outlined in the method of evaluation.
(10)	SUPPORTING DOCUMENTATION -	Indicate whether the file contains the supporting documentation required by the method of evaluation.
(11)	RECORD OF CONTACTS -	Indicate whether the file contains a record of the contacts made during the review.
(12)	COMMENTS -	Discussion of any pertinent facts relating to the case review.

S/URS WORKSHEET

Factor _____ State _____ Number cases reviewed - exception processing _____

Total From Mgmt Sum Report (2nd Previous Qtr.) _____ Required Reviews _____ Number cases reviewed - other sources _____

Qtr. Under Review _____

NAME/ID#	Source		Date of Except Run or Referral	Date Case Assigned	Date Review Initiated	Stat/Med Analysis Yes/No	Issue Addressed Yes/No	Chron. Record Yes/No	Support. Document. Yes/No	Record Contacts Yes/No	Comments
	Exc	Ref									
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)

APPENDIX B

SPR Claims Processing Review Procedures

APPENDIX B

SYSTEM PERFORMANCE REVIEW CLAIMS PROCESSING REVIEW PROCEDURES (ELEMENT 4G)

PURPOSE

The purpose of the claims processing (CP) review is to provide an ongoing mechanism for evaluating CP systems and to provide HCFA with national data on CP operations. CP findings are based on the review of a statistical sample of adjudicated claims. Analysis of CP data provides HCFA with a mechanism for evaluating Federal claims processing policies and procedures and for identifying deficient State CP practices.

OVERVIEW

The CP sample universe consists of all claims adjudicated to payment or denial including adjustments by the State agency or its fiscal intermediary. Claims are subject to sample selection in the month in which adjudication is final rather than in the month in which the services were provided or in the month in which payments were actually made to the provider. Adjustments which either increase or decrease previous payment authorizations are also subject to sample selection and review.

The CP review provides data on the incidence of CP errors and the resulting cost. Once a claim is selected for review, it is reviewed to determine (1) if it was processed in accordance with the State's CP procedures and (2) if the payment/adjustment was correct. A CP Review Schedule is completed for each claim selected for review and is used to record information regarding the errors found.

The CP review is conducted in two major phases and produces two types of findings. In the first phase, the claim is reviewed to determine if it was processed correctly. That is, was all necessary documentation present, were all required procedures followed, were coding or data entry errors made, etc. Processing errors may occur in the CP system itself, or in its supporting manual interface. It is important to review not only procedure, but also decisions. It is possible to correctly follow established procedures, but still err at various decision points within those procedures. The CP review looks at the information available at the time the claim was processed to determine if correct CP decisions were made. If processing errors were made, an occurrence error is recorded on the CP Review Schedule. Occurrence errors may or may not result in an incorrect payment/adjustment. (The State may make errors in processing the claim but the payment authorization may still be correct.)

In the second phase the reviewer develops any occurrence errors found to determine whether they caused the payment to be incorrect. Development means that CP reviewers obtain missing documentation, rework payment computations, or perform other activities necessary to determine if the payment was correct. If incorrect, a dollar error is cited on the CP Review Schedule. Dollar errors are described in terms of the type and amount of the error. A dollar

error finding is recorded on the CP Review Schedule with the occurrence error which was most responsible for the dollar error. As a result, statistical data are generated which describe the relationship between occurrence and dollar errors in State CP systems.

DEFINITIONS

Use the following definitions within the context of the CP review system.

Adjudication - That point in the claims process at which a final decision has been reached to pay or deny a claim.

Amount Approved - The amount adjudicated for payment by the State regardless of the amount of the check subsequently issued to the provider.

Dollar Error - An error that resulted in an erroneous payment; i.e., an overpayment, underpayment, or total dollar error.

Medicare Crossover Payment - Payment by the State Medicaid agency for the Medicare deductible and coinsurance amounts.

Occurrence Error - An error that occurred during processing which may or may not result in a dollar error. For the purposes of the SPR occurrence errors are only assessed where the accurate processing of claims or the accumulation of accurate claim information is affected.

Overpayment - A dollar error in which the amount approved is in excess of the correct amount.

Permissible State Practice - Written State policy instructions which are not inconsistent with the State plan or with approvable State plan amendments which have been submitted to, but not yet acted upon by, HHS.

Prior Authorization - Prior approval by the State agency to reimburse a provider for a specific service, if rendered.

Provider Listing - An official State registry of providers and facilities authorized to receive reimbursement for services provided to State Medicaid recipients.

Recipient History File - A file, covering a period of time, of medical services received by a recipient for which Medicaid reimbursement was requested. The listing should provide the information necessary to conduct the review; i.e., the service rendered, units of service, date of service, provider of the service, date of and amount approved, third party payment data, etc.

Sample Unit - A line item(s) representing the lowest level of claim/adjustment adjudication. The most detailed claim breakdown for which a payment/adjustment determination is made and authorized. For purposes of this guide, a sample unit is referred to as a "claim" in narrative discussions.

Total Dollar Error - An overpayment for the full amount approved.

Underpayment - A dollar error in which the amount approved is less than the correct amount.

SCOPE OF REVIEW

The CP review is concerned with the most detailed claim breakdown for which a payment amount was determined and authorized for payment or adjustment; i.e., the lowest level of payment adjudication by the State. In many instances the claim under review (sample unit) is a single service (office visit, drug, etc.) listed as a separate line item on the provider's invoice for which a separate payment decision is made. (Other line items appearing on the same invoice not in the sample unit are subject to separate sample selection and review.) In other instances the sample unit may be several services listed separately on the provider's invoice but grouped together for payment determination purposes, or an inclusive rate payment made for an individual beneficiary (such as some hospital services, nursing home rates, etc.).

For CP purposes, claims processing is considered complete upon final adjudication when a claim is posted to the adjudicated claims file. The claim is reviewed for correctness based on the amount approved. Adjustments (increases and decreases) made subsequent to the claim adjudication are considered separate CP actions and are subject to independent selection and review as part of the CP sample. Adjustments may be in the form of a supplemental payment, a debit or credit to the provider's account, or a new payment authorization after a credit to the provider's account for the amount of the original claim.

The CP review is not limited to the provider invoice information but includes examination of supporting documentation, recipient history files, payment fee schedules, and other source documents required to reach a definitive review finding. The review is conducted in accordance with permissible State practice and these review instructions.

Permissible State Practice and the State Plan - In all instances where State practice conflicts with the State plan (or approvable amendments) State practice is not permissible and the review is conducted in accordance with the provisions of the State plan. Although the State plan preprint is a simplified document, it is designed to be consistent with Federal regulations. Where the State plan does not specifically address an issue and State practice conflicts with Federal regulations, the review is conducted against the CFR and other HCFA guidelines. If, however, the approved State plan specifically addresses an issue but is in conflict with Federal regulations, the review is based on the approved State plan.

State plan amendments submitted for approval but not yet acted upon are considered in effect for review purposes if the amendments are approvable. Plan amendments are approvable so long as they do not conflict with the CFR. Plan amendments which conflict with Federal regulations are not approvable and cannot be honored for CP review purposes. The effective date of an approvable amendment may be prospective or retroactive, but may not be retroactive beyond the beginning of the calendar quarter in which the amendment was submitted. If the effective date of the amendment is not specified, the date it is submitted is the effective date for review purposes. Once submitted, an approvable plan amendment remains in effect unless, and until, it is formally disapproved by the Department.

Parameters of the Review - Although payments, denials, and adjustments are subject to selection in the month of adjudication, the review is conducted in accordance with policies, procedures, fee schedules, etc. in effect on the date(s) the service was provided or the date of adjudication, as specified by permissible State practice. In instances where the service was provided over a period of days, particularly from one month to the next, it may be necessary to apply separate policies or fee schedules to the review when the dates of service span the effective date of a policy or fee schedule change. For example, one fee schedule may have been in effect for some of the services performed, but a different fee schedule became effective for the remaining services provided.

CLAIMS NOT TO BE REVIEWED

Certain types of claims are not to be included in the CP sample. These will normally be eliminated in the sample selection process. Claims not to be included in the sample and considered listed in error if selected are:

- claims which are not processed through the MMIS;
- claims in which the adjudication date is not within the sample month;
- claims for which no Federal matching is claimed; i.e., are paid with State funds only;
- claims that are an end-of-year institutional cost settlement.

CP REVIEW PROCEDURES

The following sections outline the CP review steps, development, and error determination instructions. Claims are reviewed against two criteria: did the system and manual interface follow approved CP procedures (procedure criterion); and, was the claim processed correctly based on available data (decision criterion).

1. Required Documentation

   a. Claim sample selection list.

   b. Claim copy with:
      - prior authorization
      - physician certification form
      - sterilization consent form
      - Medicare EOMB

c. Provider eligibility file record.

d. Recipient eligibility file record for applicable date of service (or other State accepted proof of eligibility).

e. Claim history file: must show at least all claims for the month prior to the month the service was rendered through the date of claim adjudication. Where the State imposes frequency limitations additional claims history may be necessary to review specific claims.

f. Pricing file record.

g. For adjustments, copy of adjustment claim with required attachments.

h. Claim suspense activity record. Displays the flow of the claim through various system processing locations, edit and audit codes against which the claim excepted, and any manual force codes applied during the process. (These data may be available through a single record or multiple sources.) If manual force codes were applied, the State must provide a copy of its applicable force code procedure.

i. Remittance advice.

j. State coding manuals, decision logic tables, fail record layouts, procedure manuals, etc.

2. Claim Identification - Check the invoice or claims file to determine:

a. if the claim was properly selected for review; i.e., was not listed in error;

b. the line item(s) under review;

c. the review parameters established by the date(s) of service and/or adjudication date;

d. the length of time in elapsed days from date of receipt through date of payment (check date, not approval date) or date of denial notice; and

e. the amount approved.

3. Coding/Data Entry Accuracy - Information supplied on the claim should be coded and entered into the system accurately. Any coding or data entry errors uncorrected at the time of final adjudication are cited as occurrence errors. Where information was missing on the original claim, and was inappropriately supplied during the claims process i.e., without documentation or contrary to permissible State practice) a coding/data entry error must be cited.

4. Provider Eligibility - Determine if the provider was certified to participate in the program for the day(s) the service(s) was rendered and was certified to provide the actual service(s) rendered; e.g., laboratories providing tests outside their approved specialties. If an amount was approved for a provider who was ineligible for the dates of service or for that particular service both an occurrence and dollar error must be cited. If no amount was approved, but the claim successfully passed the provider edits, even though the provider was ineligible, an occurrence error must be cited. .

If a provider was eligible and the claim was denied based on provider ineligibility cite an occurrence error. The claim review must be completed before a determination as to dollar error can be made.

5. Recipient Eligibility - Establish that the recipient appeared on the Medicaid eligibility file for the month(s) covered by the date(s) of service or that there was other State-acceptable proof of eligibility.

6. Covered Services - Compare the type of service provided with the services covered under permissible State practice to determine if the claim was for a covered service. This includes reviewing for timeliness of claims submission. If a claim was paid without required service coverage, prior authorization or provider certification, or frequency limitations were exceeded, count an occurrence error. If the claim was denied for lack of this documentation, and it in fact existed, count an occurrence error. More detailed information on specific coverage issues is provided below.

A. Prior Authorization - Providers must obtain approval from the State prior to delivery of certain services if reimbursement is to be provided. Establish if prior authorization was required, if prior authorization was obtained and documented, and that the service provided was not in excess of any limitation set by prior authorization requirements.

Where the State provides for a waiver of prior authorization under certain circumstances, such as an emergency, verify that the waiver and subsequent authorization were granted in accordance with permissible State practice and prior to final adjudication. If waiver and subsequent authorization could have been granted but were not, an occurrence error is cited, but not a dollar error.

B Level of Care Certification - Where the State plan, or if silent, permissible State practice, requires evidence of certification prior to payment authorization, verify that the required certification was obtained. If not obtained cite an occurrence error. If certification did not exist at the time of final adjudication but an amount was approved for the claim, cite both an occurrence and a dollar error.

C. Duplicate Payment - Ascertain that a separate amount was not previously approved for the service under review; i.e., the payment under review does not duplicate a previous one. (Where a duplicate billing on a single invoice results in a duplicate payment, the claim(s) appearing after the first claim on the invoice is considered a duplicate.) To determine if the sample unit is a duplicate payment, compare the claim against the paid claims history which covers the period of time as defined in the documentation requirements. Payment of an outpatient claim which duplicates an inpatient claim utilizing an all inclusive per diem rate is an error condition.

D. Frequency Limitations - Determine whether a service was provided more frequently than allowed under permissible State practice. To accomplish this consider both the limitation on the number of times a service may be performed and any differences in the rate of payment for initial and subsequent services. Compare the claim against the claims history for the entire period of time the service under review is subject to frequency limitations under permissible State practice.

7. Provider Signature/Certification - Review State criteria regarding what constitutes an acceptable signature; e.g., signature stamp, authorization form for a substitute signature. Determine if required signatures/certifications were provided on the invoice. If not, develop missing information required to complete the review.

8. Amount Approved - Verify the correctness of the amount approved by consulting fee schedules, reasonable charge profiles, or by recalculating relative value based payments. The correct amount is the lesser of either the amount billed by a provider for a covered service or the amount specified for that service in the appropriate fee schedules, reasonable charge profiles, etc.

SPECIAL REVIEW CIRCUMSTANCES

Medicare Crossover Payments - States may provide payment for the deductible and coinsurance for beneficiaries enrolled under Medicare. For beneficiaries enrolled under Part A and Part B but not under a State buy-in agreement, payment for the deductible and coinsurance is for services covered under the State plan. At the State's option, payment under a State buy-in agreement may be made at the Medicare rate or a lower Medicaid rate.

In crossover situations, claims are usually (but not always) processed for payment by Medicare first. Medicare pays the principal part of the provider charge up to the maximum rate, less any deductible and coinsurance amounts.

In processing crossover payments the State agency ascertains the charges allowed and the amount paid (or to be paid) by Medicare. This precludes the State from paying an amount that, for assigned Part B claims, when combined with the Medicare payment, would exceed the Medicare rate. Verify that the Medicare crossover payment was correctly processed and that the claim was processed with an Explanation of Medicare Benefits (EOMB) or its equivalent and other State required documentation.

Third Party Liability - The CP review is concerned with identifying TPL occurrence errors only. Since TPL dollar errors are not within the scope of the CP review, no development of occurrence errors is necessary.

When the State's CP procedures require identification of possible TPL sources, make a determination as to whether the procedural requirements were met. The State's procedures for TPL identification may entail:

- collecting specific TPL information on the invoice;
- identification of TPL coverage already known to the system;
- TPL edits related to the type of service; or
- tracking claims with known TPL for future recovery.

Adjustments -

A. Amount - Only the net amount of the adjustment is under review. In most instances the adjustment amount is the full amount of the supplemental authorization, credit or debit. In other instances, if the initial payment was cancelled and a new payment authorized to the same provider, the adjustment is the difference between the original amount authorized and the new amount; i.e., the net amount.

Where the original payment is cancelled and a new payment authorized to a different provider, the amount of the adjustment is the amount of the cancellation. The new payment to a different provider is not considered part of the adjustment and is subject to separate sample selection.

B. Correctness - To determine the correctness of adjustments, review them in relation to the correctness of the original adjudication and any prior adjustments. To be correct, the adjustment must be based upon an accurate assumption. For example, an adjustment may be authorized to increase an original payment. This assumes that the original payment was less than can be allowed under permissible State practice. If, however, a review of the original authorization revealed an overpayment, the assumption and adjustment are in error.

Examine both the adjustment and the original adjudication to determine the correct total payment. That is, identify and develop occurrence errors in order to determine the correctness of the original adjudication. Review the adjustment to determine if any original errors found, both occurrence and dollar, were corrected

or otherwise compensated for by the adjustment. If not, the errors carry forward and are coded on the CP Review Schedule for the adjustment. If, for example, a claim was originally processed without required documentation and this documentation was needed to make the adjustment, code an occurrence error to the adjustment if it was not obtained. Of course, an adjustment to cancel the original payment authorization due to a lack of required documentation would be correct. Likewise, any dollar errors occurring in the original payment authorization, if not corrected in the adjustment process, may contribute to an adjustment dollar error. Mass adjustments should be excluded when charging errors which carry forward from prior claims action.

The following outlines the dollar error findings which may result from adjustment reviews.

1. Original Authorization Correct and Paid in the Amount Specified in the Appropriate Fee Schedule -

a. Adjustment to Increase - Net increase reported as total dollar error.

b. Adjustment to Decrease - Net decrease reported as underpayment.

2. Original Authorization Correct but Provider Billed Less Than Specified in Appropriate Fee Schedule -

a. Adjustment to Increase - Correct only if provider requests adjustment.

(1) Net increase correct if in amount of adjustment request or amount specified in the appropriate fee schedule, whichever is the lesser.

(2) Underpayment coded if net increase is less than the correct adjustment as specified in (1) above.

(3) Overpayment coded if net increase is more than the correct adjustment as specified in (1) above.

b. Adjustment to Decrease - Net adjustment reported as underpayment.

3. Original Authorization a Total Dollar Error -

a. Adjustment to Increase - Net amount of increase reported as total dollar error.

b. Adjustment to Decrease -

(1) Any amount of decrease correct up to the amount of original payment authorization.

(2) Any amount of decrease beyond original payment authorization reported as an underpayment.

4. Original Authorization an Overpayment -

a. Adjustment to Increase.—Net amount of increase reported as a total dollar error.

b. Adjustment to Decrease -

(1) Any amount of decrease correct up to the amount of the original overpayment.

(2) Any amount of decrease beyond original overpayment amount reported as underpayment.

5. Original Authorization an Underpayment -

a. Adjustment to Increase -

(1) Any amount of increase correct up to the amount of original underpayment.

(2) Any amount of increase beyond original underpayment reported as overpayment.

b. Adjustment to Decrease -

(1) Net decrease reported as an underpayment.

DEVELOPMENT AND ACTUALIZATION

Development is the process of determining CP Review information needs and obtaining that needed information when the claim and associated documentation furnished by the State are insufficient to support the adjudication decision. It may be that the documentation was never available or it may erroneously not have been forwarded. The specific circumstances control the error determination process.

Actualization refers to the process of determining whether an occurrence error resulted in a dollar error. Thus, it is a special form of development. With the exception of TPL occurrence errors, all occurrence errors are subject to development to the point necessary to determine the effect of the error on the payment adjudication. Although all occurrence errors are cited on the Claims Processing Review Schedule, development to determine dollar errors ceases at the point a total dollar error is found; i.e., the full amount of the claim should have been disallowed. Therefore, develop first those occurrence errors found which could result in a total dollar error.

When necessary to obtain documentation that was required, but missing when the claim was processed, contact the State to obtain the missing documentation. If the State is able to supply documentation and demonstrate that it was available when the claim was processed, no dollar error is cited. If the State must obtain new documentation (i.e., contact the provider, etc.), the correctness of the payment is based upon the new documentation. If the required documentation cannot be obtained or is unacceptable, cite a dollar error. For example, if evidence of prior authorization cannot be obtained, it must be assumed that prior authorization was not granted. Where system cannot produce paper or film documentation (e.g., only available on-line) the RO must validate the data on-site.

Error Determination - In making an error determination, first record all occurrence errors found using the error code which best describes the error. Determine if the occurrence error(s) resulted in a dollar error(s). If so, record the error type which best describes the dollar error.

Although the CP review is designed to establish a cause and effect relationship between occurrence and dollar errors, the relationship is not always one-to-one. For example, three occurrence errors occur during the processing of the claim, but only one dollar error results. Code all three occurrence errors on the review schedule, but record the resulting dollar error only once. In such instances, determine which occurrence error most directly caused the dollar error.

If the State cannot furnish required documentation timely, occurrence errors are actualized as dollar errors. A suggested schedule for control of the CP review process is found at Appendix D.

ERROR CODES

The error code listing contains a description of CP errors and contains codes necessary for completion of the CP review schedule.

Occurrence Error Codes - All errors are assigned to five codes as follows: (1) Coding/Data Entry, (2) Eligibility, (3) Coverage, (4) Payment, and (5) TPL/Other. These error codes are recorded under the Occurrence heading (Item 10A) of the CP Review Schedule and, with the exception of the TPL related errors, are subject to development to determine if there was also a dollar error. Since further development stops when a total dollar error is found, development should be completed first on those occurrence errors most likely to result in a total dollar error.

1. Coding/Data Entry - Cited when an error is made by the State in coding invoice or payment data, or in entering data unless corrected by the time of final adjudication.

2. Eligibility - Cited when the provider or recipient was not certified as eligible to participate in the Medicaid program during part or all of the service date(s) or the provider was not eligible to provide the service rendered and the claim was paid.

3. Coverage - Cited when permissible State practice prohibits reimbursement for the type or number of service(s) under review. Where coverage is contingent upon the presence of a prior authorization or provider certification and the claim was paid without it, cite a coverage error. If a claim was denied for lack of such documentation, but it was available, also cite a coverage error.

4. Payment - Cited when a computation or payment determination error resulted in an incorrect amount approved (which may be zero) and when errors were made in applying reasonable charge rates, fee schedules, etc, or a duplicate claim was paid.

5. TPL/Other - Cited for non-permissible State practice such as missing signature, known TPL not considered or other error in procedure not specifically listed. TPL-related errors are not subject to development.

Dollar Error Type Codes - There are six error types: (1) No Dollar Error, (2) Total Dollar Error, (3) Overpayment, (4) Underpayment, (5) TPL Procedural Error, and (6) Nondeveloped Procedural Error. A dollar error type must be assigned for each occurrence error.

1. No Dollar Error - Occurrence errors which, when actualized, did not result in a dollar error.

2. Total Dollar Error - Dollar errors in which the full amount of the payment under review should have been disallowed; i.e., an overpayment in the full amount of the payment. Development ends after a total dollar error is identified.

3. Overpayment Error - Dollar errors in which the amount approved was in excess of the correct amount.

4. Underpayment Error - Dollar errors in which the amount approved is less than the correct amount.

5. TPL Occurrence Error - Occurrence errors only. Do not develop these errors to determine if a dollar error resulted. TPL occurrence errors exist when payment is authorized without regard to known TPL information or when required TPL information is missing.

6. Nondeveloped Occurrence Error - Occurrence errors which were: a) not developed to determine if they resulted in a dollar error, or b) resulted in a dollar error but the dollar error is assigned to another occurrence error. Use code 6 to designate occurrence errors which were not developed because actualization ceased after identifying a Total Dollar Error or when several occurrence errors resulted in the same dollar error. (Since the dollar error is coded with the occurrence error most responsible, code other occurrence errors as type 6 - Nondeveloped.)

CLAIMS PROCESSING REVIEW SCHEDULE

Complete a CP Review Schedule (following page B-15) for each sample unit selected for review. Regions should reproduce the schedules locally. Instructions for properly completing each schedule item are given below.

Claim Status - Circle the appropriate abbreviation: CP (clean practitioner), NC (nonclean practitioner), NP (nonpractitioner). This item supports Element 3F. Use Appendix C to classify claims as practitioner or nonpractitioner.

1. Sample Unit Number - Enter the claim control number (invoice - line item number) which identifies within the MMIS the sample unit selected for review.

2. State Code - Enter the two-letter USPS abbreviation for the State in which the review was selected.

3. Sample Month/Year - Enter the month and year that corresponds to the specified sample month from which the sample unit was selected. Use numbers only in the format MMYY.

4. Stratum/Substratum ID - Enter the stratum/substratum identification code which matches the State determined stratum from which the claim was selected (Mandatory CPAS States).

5. State Review Number - Enter the six digit review number used by the State (Mandatory CPAS States).

6. Processing Time - Enter the applicable processing date(s) for the reviewed claims.

   From: Enter the date of receipt in the format MMDDYY. To: Enter the date of the check, remittance advance or denial notice in the format MMDDYY for the claim under review, if issued the same day as generated. If not, the region must develop a procedure to determine actual dates.

7. Elapsed Processing Days - Enter the total number of days from item 6. Count both the day of receipt and the check/notice day.

8. Amount Approved - Enter the amount approved from the claims history. This is the amount allowed for the claim; however, it may be more than the amount actually paid due to offsets/debits against the providers' receivables; e.g., "zero-pay" claims.

9. Review Results - Circle the letter that corresponds to the review results on the sample unit.

   a. Correct - Circle "a" if no occurrence errors were found during the review.

b. Occurrence Error - Circle "b" if only occurrence errors were found during the review.

c. Dollar Error - Circle "c" if occurrence errors actualized in dollar errors were found during the review.

10. Error Data - Complete this section for each sample unit determined to contain an occurrence error; i.e., number b or c was circled in item 9.

Occurrence Errors

A. Code - Record the codes for all occurrence errors identified during the review. The acceptable codes - Coding/Data Entry, Eligibility, Coverage, Payment, TPL/Other are described on page B-11 of this appendix. If more occurrence errors are found on a claim than can be recorded on the CP Review Schedule, use an additional schedule. Complete Items 1, 2, 3, 9, and 10 on the additional schedule and staple it to the original schedule.

Dollar Errors -

Develop each occurrence error recorded to determine if it resulted in a dollar error.

Exceptions: TPL occurrence errors are not developed. Secondly, if the actualization of an occurrence error results in a Total Dollar Error (the full amount of the paid claim being overpaid), the review ends without the development of the remaining occurrence errors. An overpayment or underpayment, however, does not end the review because subsequent errors may offset or compound the first error found.

After actualization of an occurrence error, enter the dollar error data directly across from the occurrence error; i.e., in line with the occurrence error code.

B. Type - Enter the type of the dollar error. The acceptable types - (1) No Dollar Error, (2) Total Dollar Error, (3) Overpayment, (4) Underpayment, (5) TPL Procedural Error, (6) Nondeveloped Procedural Error - are described on pages 11 and 12 of this appendix.

C. Amount - If a 2, 3, or 4 is entered under item 10B, Type, enter the amount, in dollars and cents, of the error. If the number 1, 5, or 6 is entered, the amount field is left blank.

11. Summary - Complete this section if any dollar error amount was recorded in item 10C. If multiple CP Review Scedules are used for a sample unit, complete Item 11 on the original schedule only.

A. Net Dollar Error - Enter the net dollar amount of all dollar errors combined. The net error amount is determined by adding all overpayments together and subtracting all underpayments and is the difference between the amount approved and the correct approval amount.

B. Type - Circle the number which corresponds to the type of the net error finding.

1. No Net Dollar Error - Circle the number "1" if no net dollar error amount.

2. Total Dollar Error - Circle the number "2" if the net amount of all dollar errors results in an overpayment in the full amount of the payment authorization (item 8).

3. Overpayment - Circle the number "3" if the net amount of all dollar errors results in an overpayment but not in a total dollar error.

4. Underpayment - Circle the number "4" if the net amount of all dollar errors results in an underpayment.

Claim Status

CP NC NP

SPR

CLAIMS PROCESSING REVIEW SCHEDULE

1. Sample Unit Number _____

2. State _____

3. Sample Month/Year _____

4. Stratum/ Substratum I.D. _____

5. State Review Number _____

6. Processing Time
From: _____
To: _____

7. Elapsed Processing Days _____

8. Amount Approved _____

9. Review Results

a. Correct

b. Occurrence Error

c. Dollar Error

10. Error Data

OCCURRENCE ERRORS	DOLLAR ERRORS	
A. Code	B. Type	C. Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

11. Summary

A. Net Dollar Error _____

B. Type 1 2 3 4

APPENDIX C

Practitioner And Non-Practitioner Claim Types

APPENDIX C

Practitioner and Non-Practitioner Claim Types

This listing is used for determining appropriate claim status under Element 3F and making appropriate entries on the CP Review Schedules.

Practitioner Claims

1. Physician's Services (medicine and osteopathy)
2. Dental Services
3. Clinic Services
4. Family Planning Services (rendered by a physician, clinic, or other practitioner)
5. Laboratory and X-ray Services
6. Prescribed Drugs
7. Early and Periodic Screening
8. Rural Health Clinic Services
9. Sterilization Services (rendered by a physician, clinic or other practitioner)
10. Other Practitioner's Services (chiropractors, podiatrists, psychologists, registered or licensed practical nurses providing private duty nursing services, optometrists, physical therapists, occupational therapists, speech pathologists, audiologists, and Christian Science practitioners)

Non-practitioner Claims

1. Inpatient Hospital Services
2. Mental Hospital Services for the Aged
3. Outpatient Hospital Services
4. SNF/ICF Mental Health Services for the Aged
5. Inpatient Psychiatric Facility Services for Individuals Age 21 and Under
6. ICF Services for the Mentally Retarded
7. ICF Services - All Other
8. SNF Services
9. Home Health Services (includes personal care services, home/community-based services)

10. Family Planning Services (rendered by a hospital in/outpatient)

11. Sterilization Services (rendered by a hospital in/outpatient)

12. Other Care (transportation, prosthetic devices, durable medical equipment, eyeglasses billed by an optician)

APPENDIX D

Suggested CP Review Control Schedule

APPENDIX D

Suggested CP Review Control Schedule

1. Claim Universe - all claims adjudicated during the review month.
2. Sample Selection - by 15th of the second month.
3. Claims Documentation - by 1st of third month (received in region).
4. CP Review Complete - by 20th of third month.
5. State Notification - by 25th of third month.
6. State Response - by 5th of fourth month.
7. Final Error Determination - by 10th of fourth month.

Whenever possible requests for additional documentation should be made by telephone. Two fixed dates are:

> March 25 - Official EWS notification (where necessary) of potential failure of Element 4G based on review of at least 90% of 1st quarter sample.
>
> June 15 - Report to central office on 100% of 1st and 2nd quarter samples.

APPENDIX E

Data Validation Review

I. Introduction and Overview

Despite recent improvements made in Medicaid statistical reporting, a significant number of Medicaid reporting problems remain which negatively impact on the quality of the statistical data HCFA receives from State agencies. The continued presence of these reporting problems justified the establishment of a data validation program by HCFA. The focus of the program is to validate the accuracy of data reported to HCFA by means of reviewing the quality of the State systems for collecting and reporting data on the Annual Statistical Report on Medical Care (HCFA-2082) and the Monthly Statistical Report on Medical Care (HCFA-120). However, due to the proposed modifications to the statistical reporting system, only deficiencies relating to areas which will be carried forward to the revised HCFA-2082 or the Quarterly Claims Workload Report (HCFA-441) will be brought to the States attention for corrective action.

The procedures for validating Medicaid statistical data are designed to determine the capability of State information systems for generating data which meets Federal reporting requirements and to detect Medicaid reporting problems resulting from systems design deficiencies. The analysis of State systems will be done by examining the outputs, inputs, and processes of State systems as they relate directly to the development of data for Federal statistical reporting. The various steps of the review process are explained more fully in the remaining sections of this guide.

II. Preliminary Review

A. Review of Federal Reports Submitted

1. Central Office Review

Central Office (CO) staff will review prior year HCFA-2082 and 120 reports to identify potential problem areas. A list of the potential problems and where they appear on the reports will be provided to the regional offices prior to the on-site visits.

The CO review will include applying the edits included in State Medicaid Manual Section 2700 as well as additional consistency and reasonableness checks. The edits in Section 2700 deal primarily with surface inconsistencies such as columns not adding when they should or vice versa and differences in totals on related sections of a report. The additional checks which will be applied include the following:

a. Comparisons of related data elements within an individual State report. For example a potential reporting problem would exist if Section A of a 2082 shows 9,000 aged recipients of inpatient hospital services and Section E shows only 1,000 aged recipients being discharged from inpatient hospitals during the year.

b. Comparisons of data on the HCFA-120 and 2082 reports. For example, a potential problem would exist if more aged recipients were reported on one monthly HCFA-120 than were reported on the yearly HCFA-2082.

c. Comparisons of data on the same report for different time periods. For example, a potential problem would exist if the total reported expenditures for inpatient hospital services tripled from FY 1981 to 1982 while there was no change in the number of recipients of that service.

2. Regional Office Review

After receipt of the list of potential reporting problems from CO, regional office (RO) staff will review any available current year reports and the State plans:

a. To further examine the potential problems. The RO should discuss with State staff problems identified by CO which subsequently appear to be corrected to determine what, if any, corrective action(s) were taken. For problems resulting from data omissions, the RO should review the State plans to determine if such omissions resulted from non-coverage of certain service types or eligible groups.

b. To identify any additional potential problems. In reviewing current reports, RO staff will not be expected to perform the full range of edits used by CO. The RO review is only expected to identify any obvious omissions or discrepancies. The RO should also utilize State plans to identify potential reporting problems. For example, a potential problem would exist if a State was reporting data for clinic services and did not cover the service according to its State plan.

B. State Systems Documentation Review

1. Requesting State Systems Documentation

The RO should request States to furnish systems documentation relating to Federal reporting. The essential types of documentation to be submitted are the crosswalks (type of service and recipient) which describe how State data categories are converted into Federal reporting categories, and the feeder reports from which data are extracted to produce the Federal reports. Examples of type of service and recipient crosswalks (Attachments A and B) and feeder reports (Attachment C) are provided to show the appropriate level of detail to be requested. While States are not required to duplicate the formats the same level of detail should be provided.

In addition, States should also be requested to submit any additional supporting documentation such as:

a. Types of claim forms, the types of providers that can use each form, and the types of services that can be billed on each claim form.

b. State type of service listings with respective identifying codes.

c. State type of provider and provider specialty listings with respective identifying codes.

d. State recipient category listings with respective identifying codes.

e. Other listings of codes used in the crosswalk determination logic such as place of service, procedure codes, etc.

Because States may not have the requested information readily available, the request should be made at least one month in advance of the on-site review date.

2. Crosswalk/Review

The crosswalks describe how State data categories are converted into Federal reporting categories. For example, while a State may separately identify podiatrists services for its purposes, Federal reporting instructions would require podiatrists services to be reported under Other Practitioners Services. The crosswalk should show that the Federal Other Practitioners Services category does include podiatrists services.

In addition to listing which types of State categories are collapsed into Federal categories, the crosswalks should also show the systems logic used to recategorize the State breakouts to meet Federal reporting requirements; i.e., the number of logical steps that a system would perform to determine the proper categorization of data. Some data elements may require only one step while others would require many more. For example, in Attachment A on page 13 we find that only a single step is required for categorizing podiatrist services to Other Practitioners Services since there is no other information needed to make a determination in either the Category of Service or Other Criteria columns. Therefore, data for all claims with a Provider Type 6 would be reported under Other Practitioners Services on the Federal reports.

On the other hand, if we looked at physician services on page 13, Attachment A, we would see that several steps are involved since there are four possible Federal service categories in which the data could be reported. The determination of the appropriate Federal category would be made by considering the Type of Provider, the Category of Service, Other Criteria and the order in which these criteria are to be reviewed. In the previous example for physician services, there are five lines to be used for determining the proper Federal reporting category. To determine the Federal type of service, the criteria in each line must be reviewed in succession. First, the procedure codes must be reviewed to determine if the service was a sterilization, in which case the data would be reported under sterilization services instead of physician services for Federal reporting. Second, if the category of service is type 24, family planning physician, then the data would be reported

under family planning. Third, if the category of service is prescribed drugs and the therapeutic class is 63 then the Federal category would again be family planning, and so on.

In the previous example for categorizing data from physician claims, a potential error can be seen in the determination logic. According to the instruction in State Medicaid Manual Section 2700, laboratory and X-ray services should include services of physicians who provide only such services (radiologists and pathologists). The sample crosswalk for categorizing physician services does not make allowance for this provision. According to the crosswalk, it appears that all radiologist and pathologist services would be reported under physician services. This then would be a potential error to be discussed with the State.

Although the above examples apply to type of service crosswalks, the same logic would apply to the recipient crosswalks. The crosswalks would need to identify for each of the State categories of assistance the appropriate Basis of Eligibility (aged, blind, disabled, AFDC adult, AFDC child, or other Title XIX) and Maintenance Assistance Status (categorically needy receiving or not receiving maintenance assistance or medically needy).

3. Feeder Report Review

The feeder reports are individual State reports from which data are extracted for the Federal reports. They usually are produced by the different States components which have responsibility for the various sections of the Federal reports; e.g. eligibility payment, recipient, or claims processing data. The various reports are then all submitted to the State component which has responsibility for compiling the data and producing the Federal reports. In general, the feeder reports will help point the RO reviewer to the responsible component for discussion of the potential problems identified, which will help save both the RO and State time during the on-site phase of the review.

Examining the feeder reports will allow the reviewer to potentially determine if the responsible component was given sufficient information to accurately produce the Federal reports. In some cases the format of data submitted on the feeder reports would make it impossible for the compiler to accurately produce the Federal reports. For example, according to the Federal reporting instructions, each cell on Section A of the HCFA-2082 should include an unduplicated count of recipients. Therefore the number of recipients of Other Practitioner's Services should be unduplicated across chiropractors, podiatrists services, etc. If the feeder report separately identified the unduplicated number of recipients of chiropractors and podiatrists services, then an overall unduplicated count of Other Practitioners Services could not be developed for Federal reporting, since the

compiler would not know if anyone received both types of services. All the person compiling the HCFA-2082 could do is add the recipient counts together which would result in duplicate counting.

The feeder reports will also be useful in determining the source of problems identified during the sample review of Federal reports submitted by the States. An example would be where the data for a cell has been omitted. If the data is on a feeder report but has not been carried over onto the Federal report, this would most likely be a typing oversight and correctable by the compiling component. If the data is also missing from the feeder report then the reviewer would need to discuss the situation with the component responsible for completing the feeder report to determine if it is a system error. It may also have to be carried one step further and discussed with the policy staff to determine if the omission is due to non-coverage of the item by the State. This could indicate a discrepancy in the State plan since the RO should have already reviewed their version prior to the State visit and determined that it was covered according to their records.

III. On-site Review

RO staff will make on-site visits to each State. The scope of the on-site visit will vary depending on the amount of information available during the preliminary CO/RO review. CO will accompany RO staff on selected State visits. In general, the on-site visit will include:

A. Reviewing State systems documentation (if not available in RO).

B. Interviewing appropriate State and contractor staff to obtain information needed to complete the validation of specific areas on each HCFA report. The reviewer should utilize the interviews to obtain information not available from the review of State systems documentation and sample State reports and to confirm and/or follow-up on information found in the documentation reviews. Interviews should be conducted with State and/or Contractor staffs having responsibility for preparing the HCFA statistical reports and State and/or contractor staff responsible for designing and maintaining State information systems. Where State/contractor staff are not able to provide satisfactory explanations during the on-site visits, the opportunity to respond will accompany issuance of the draft report.

C. Addressing, the following issues:

Areas Which Could Result in Corrective Action

1. Distinguishing Federally Matchable From State-Only Payments

   Determine whether those States that have a State-only medical assistance program (non-Title XIX), are separately identifying the data to exclude it from data for Title XIX services.

2. Reporting of All Required Medicaid Data on the Federal Reports

   Determine if there are any required types of Medicaid data not reported on the Federal reports.

3. Unduplicating of Recipients

   Determine if each cell of the applicable sections of the Federal reports contain unduplicated recipient counts.

4. Title XVIII Crossover Claims Data

   Determine if the State has properly reported crossover claims data throughout the reports.

5. Determining the Age of Recipients

   Determine if the State uses the age of recipients as of March 31 for reporting purposes.

IV. Report Development

A. Draft Report

Following the on-site review, the RO will draft a preliminary report of findings. The draft report will include the following sections:

1. Reporting Deficiencies

   This should include a detailed description of each reporting deficiency identified.

2. SPR Score Sheet (Applicable only to MMIS States)

   This should be initially completed by the RO with the assumption that all problems identified will require corrective action. (See Part V Scoring Method)

3. Corrected Reporting Problems

   This should include a description of corrective action already taken and the effective date of the action to correct problems identified on prior year reports.

4. Systems Documentation

   This should include a copy of the crosswalks and other systems documentation obtained from the State.

The preliminary report will be submitted to CO within two weeks of the review's completion. CO will review and identify which of the reporting problems will require State corrective action. The CO decision will take into consideration the ambiguity of any existing instructions and the future elimination of certain data from proposed report revisions.

While most of the reporting instructions are clear, some ambiguity may exist. Identification of ambiguous instructions will be made by CO based on the overall analysis of review results for each State. Consequently, for each error identified, the RO reviewer should provide in the draft report adequate information to enable CO to determine whether or not this particular situation will be scored.

In addition, contemplated revisions to the HCFA-120 and HCFA-2082 in the near future will also dictate which of the findings will be scored. Because a final decision on the contemplated revisions will not be made prior to the review, the reviewer is asked to temporarily score each finding. A final determination will then be made by CO staff. A State will be asked to take corrective action on only those findings deemed necessary to meet future reporting requirements. All other findings will be noted "for the record" and used in analyzing and explaining past data submitted.

The draft report should be addressed to:

Director, Division of Reports and Analysis
HCFA/BQC/OPQE
Room 264 East High Rise
6325 Security Blvd.
Baltimore, Md. 21207

B. Final Report

After obtaining CO comments, the RO will make necessary revisions to the report and submit it to the State for review and comment. When the State's comments are received, the RO will make any appropriate changes and complete the final report. The final report will include revised Sections 1-2 of the preliminary report. Sections 3-4 will be replaced by a new Section 3 entitled State Comments which describes the State's comments and any resultant changes made to the report. A copy of the final report should be sent to the Division of Reports and Analysis in CO, the State, and incorporated into the SPR report.

V. Scoring Method

To facilitate scoring, point values have been assigned to every data cell on the HCFA-120 and HCFA-2082 reports. These point values weight the various data elements contained in the reports. The point value assigned to each cell reflects its importance in relation to Medicaid expenditure, the number of recipients, congressional interest, etc. The scoring sheets for the validation reviews will be the actual HCFA-120 and HCFA-2082 report forms. Data-cell values for each form are listed in Attachment D.

A. Errors

Only systems errors are to be scored on the validation review. Other types of discrepancies noted on the statistical reports which are found to be the result of clerical errors (such as errors in transcription) should be scored under Factor 515 of the SPR.

The most common system errors will be errors in the classification of types of service or eligibility categories. These errors will usually affect several sections on both reports. Other errors can occur which affect only a particular section. A more detailed discussion of classification errors and how they should be scored follows:

1. Type of Service Classification

An error in the classification of types of service occurs when a particular State category of service has been placed into the wrong Federal classification, as described in Section 2700 of the State Medicaid Manual. For example, Section 2700.2, Appendix A, states that chiropractor services should be reported under "Other Practitioner." If a State system is categorizing chiropractor services under "Physician Services," then an error should be scored. As in the above example, classification errors almost always affect more than one type of service, overstating one type of service and understating the other. For this reason, all data cells affected by the classification error (those under "Other Practitioner" and those under "Physician Services") would be checked or lined out on Section A and B of the HCFA-2082, and Part 1, Section B of the HCFA-120. These errors may also cause data cells on Sections C and D of the HCFA-2082 to be incorrect. (These sections deal with age, sex, and race data arrayed by type of service.) Reviewers should be careful then, to determine all data cells affected by these errors throughout all sections of both statistical reports.

Reviewers should also be aware that a classification error in a particular type of service does not necessarily render every data cell involving that type of service incorrect. For example, a classification error involving "EPSDT" probably would not affect data cells 03-03, 09-03, or 16-03 on page A04 of the HCFA-2082, because these cells involve aged recipients who are not eligible for EPSDT services. (Conversely, the reviewer can assume that, if these cells show any amounts other than zero, the data is most likely incorrect.)

Occasionally, the reviewer will determine that a classification error exists, but will not be able to determine all types of service adversely affected by the error. This most often occurs for errors involving those types of service which are not defined by a unique provider type (e.g., "EPDST," "Family Planning"). In the case of a State not being able to separately identify EPSDT, for example, several other types of service may or may not be inflated ("Physicians Service," "Clinic Services," "Other Practitioner," and perhaps others). In this situation the reviewer would score errors in only those data cells involving EPSDT, and should not try to guess which other types of service are affected by the classification error.

2. Eligibility Classification

As is the case with type of service classification errors, in the placement of State categories of eligibility into the Federal categories defined in Section 2700 of the State Medicaid Manual may affect data cells in many sections of both the HCFA-120 and HCFA-2082. For example, a particular State cannot differentiate between AFDC children and AFDC adults. Both groups of eligibles are lumped together in the data for AFDC children. Zeros are shown in the data cells for AFDC adults. The data for both bases of eligibility is incorrect. Potentially then, each cell in rows 06, 07, 12, 13, 19 and 20 is wrong for each page of Sections A and B of the HCFA-2082. Each section of the reports where data is arrayed by basis of eligibility is probably also incorrect for these two bases of eligibility (HCFA-2082, Sections E, F, G, H and I; HCFA-120, Parts II and III).

B. Calculation of Score

To determine a State's score on the data validation review, the reviewer should annotate those data cells which have been found to be incorrect due to system's errors on the HCFA-120 and HCFA-2082 scoring sheets. The reviewer should place an X or line through each data cell that is incorrect and place the appropriate finding number (or numbers if there is more than one error involved) in the cell, so that central office will know the reviewer's basis for determining that the data for that cell in incorrect. (See Attachment E for an example of how to score on the scoring sheets.)

The reviewer would then total the point values for each incorrect data cell to derive the State's total score. Reviewers should take care not to score any particular data cell as being incorrect more than once. While several errors may effect a particular cell, it can only be scored as incorrect once. However, all findings (errors) should be noted on the scoring sheets and in the review report, even though they may only affect data cells that have already been determined to be incorrect from a prior finding. In order to avoid being penalized the point value for a particular cell, the State must correct all errors affecting that cell.

A State's validation score is converted to SPR penalty points as follows:

Validation Score	SPR Penalty Points
0-100	1 Bonus Point
100-200	0 Points
201-300	1 Penalty Point
301-400	2 Penalty Points
401-500	3 Penalty Points
501-600	4 Penalty Points
601-700	5 Penalty Points
701-800	6 Penalty Points
801-900	7 Penalty Points
901-1200	8 Penalty Points
1201 or more	9 Penalty Points

The weight of the validation review (Factor 514) in the SPR is 1.5.

TYPE OF SERVICE

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
1 - Inpatient Hospital		Diagnosis codes ICDA-8, V090, ICDA/CM, V-25.2	19 - Sterilization Services
	22 - Family Planning, Inpatient		14 - Family Planning Service
	23 - Family Planning, Outpatient		14 - Family Planning Service
	25 - Family Planning, Clinic		14 - Family Planning Service
	10 - Prescribed Drugs	Therapeutic class = 63	14 - Family Planning Service
	1 - General Inpatient		01 - Inpatient Hospital Services
	3 - Tuberculosis Inpatient		01 - Inpatient Hospital Services
	41 - Medicare Part A Cross-over		01 - Inpatient Hospital Services
	13 - ICF Services		06 - Intermediate Care Facility, All Other
	12 - Skilled Nursing Home Care		07 - Skilled Nursing Facility Services
	4 - General Outpatient		11 - Outpatient Hospital Services

TYPE OF SERVICE (continued)

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
1 (continued)	29 - Ambulance		20 - Other Care
2 - Mental Hospital	1 - Mental Inpatient	Basis of Eligibility = 1	02 - Inpatient Mental Health Facility Service, Mental Health Services for the Aged
	12 - Skilled Nursing Home Care	Basis of Eligibility = 1	03 - Inpatient Mental Health Facility Services, SNF and ICF for the Aged
	1 - General Inpatient	Recipient Age 21 and Under	04 - Inpatient Mental Health Facility Services, Inpatient Psychiatric Facility Services for Age 21 and Under
	2 - Mental Inpatient	Recipient Age 21 and Under	04 - Inpatient Mental Health Facility Services, Inpatient Psychiatric Facility Services for Age 21 and Under
	4 - General Outpatient		11 - Outpatient Hospital Services
3 - Tuberculosis Hospital	1 - General Inpatient		01 - Inpatient Hospital Services
	4 - General Outpatient		11 - Outpatient Hospital Services

TYPE OF SERVICE (continued)

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
4 - Dentist			09 - Dental Services
5 - Physician		Diagnosis code - Sterilization ICDA-8-VO90, ICDACM-V-25-2	19 - Sterilization Services
	24 - Family Planning Physician		14 - Family Planning Service
	10 - Prescribed Drugs	Therapeutic Class = 63	14 - Family Planning Service
	19 - Screening		17 - Early and Periodic Screening
	All other		08 - Physician Services
6 - Podiatrist			10 - Other Practitioner Services
7 - Optometrist	19 - Screening		17 - Early and Periodic Screening
	All Other		10 - Other Practitioner Services
8 - Optician			10 - Other Practitioner Services
9 - Pharmacy	10 - Prescribed Drugs	Therapeutic Class = 63	14 - Family Planning Service
	All Other		16 - Prescribed Drugs

TYPE OF SERVICE (continued)

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
10 - Home Health Agency			13 - Home Health Services
11 - Christian Science Sanitorium			10 - Other Practitioner Services
12 - Independent Lab and X-ray			15 - Lab and Radiology Services
13 - Ambulance Services			20 - Other Care
14 - Medical Supplies/ Durable Medical Supplies			20 - Other Care
15 - Private Non-medical Institution			20 - Other Care
16 - Clinic-Other		Diagnosis codes - Sterilization ICDA-8-VO90, ICD-9-CM, V-25-2	19 - Sterilization Services
	23 - Family Planning, Outpatient		14 - Family Planning Services
	10 - Prescribed Drugs		14 - Family Planning Service
	All Other		12 - Clinic Services

TYPE OF SERVICE (continued)

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
17 - Physical Therapist			10 - Other Practitioner Services
18 - Chiropractor			10 - Other Practitioner Services
20 - Skilled Nursing Facility (SNF)	13 - ICF Services 12 - Skilled Nursing Home Care		06 - ICF Services, All Other 07 - Skilled Nursing Facility Services
21 - Intermediate Care Facility (ICF)	13 - ICF Services		06 - ICF Services, All Other
24 - Mental Health Clinic			12 - Clinic Services
25 - Psychologist			10 - Other Practitioner Services
26 - Intermediate Care Facility/ Mentally Retarded (ICF/MR) (Nursing)			05 - ICF/MR
27 - Family Planning Organization			14 - Family Planning Service
28 - Psychological Exam			10 - Other Practitioner Services

TYPE OF SERVICE (continued)

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
29 - Audiologist	19 - Screening		17 - Early and Periodic Screening
	All Other		10 - Other Practitioner Services
30 - Speech Pathologist	19 - Screening		17 - Early and Periodic Screening
	All Other		10 - Other Practitioner Services
31 - Speech/Hearing Center	19 - Screening		17 - Early and Periodic Screening
	All Other		10 - Other Practitioner Services
33 - Occupational Therapist			10 - Other Practitioner Services
34 - Hearing Aid Dealer			20 - Other Care
35 - Dental Clinic	19 - Screening		17 - Early and Periodic Screening
	All Other		09 - Dental
36 - Rehabilitation Center			20 - Other Care

TYPE OF SERVICE (continued)

Provider Type	Category of Service	Other Criteria	Type of Service for Federal Reporting
37 - Certified Rural Health Clinic			18 - Rural Health Clinic Services
38 - Ambulatory Care Clinic		IF XIX Service	20 - Other Care
39 - ICF/MR Boarding Care			05 - ICF/MR
	Unclassified* * Unclassified category of assistance not classifiable by provider type		20 - Other Care

Recipient Crosswalk

CONVERSION INSTRUCTIONS

Basis of Eligibility

The following table presents the information necessary for classifying [redacted] Medicaid recipient categories as to Basis of Eligibility for Federal Reporting.

[redacted] Recipient Aid Category	Federal Reporting Basis of Eligibility
SA, OA, MA, RA, NA	1
SB, OB, MB, RB, NB	2
SD, OD, MD, RD, ND	3
FF, FM, RF - Recipient under 21 and not case head	4
FF, FM, RF - Recipient is case head	5
CW	6

Maintenance Assistance Status

The following table presents the information necessary for classifying [redacted] Medicaid recipient categories as to Maintenance Assistance Status for Federal Reporting.

[redacted] Recipient Aid Category	Federal Reporting Maintenance Assistance Status
SA, OA, SB, OB, SD, OD, FF	1
MA, MB, MD, CW, RA, RB, RD, FM, RF	2
NA, NB, ND, NF	3

Client Master File M-seg Code	Category of Assistance Code	MMIS Aid Category	Medical ID Code	Definition
A	SA	01	MM	SSI-Aged
B	SB	02	MM	SSI-Blind
C	SD	03	MM	SSI-Disabled
D	OA	22	MM	Optional-Aged
E	OB	09	MM	Indochinese Refugees
F	OD	24	MM	Optional-Disabled
G	NA	18	MI	Medically Needy-Aged
H	NB	19	MI	Med. Needy-Blind
I	ND	20	MI	Med. Needy-Disabled
J	NF	21	MI	Med. Needy-AFDC Relat.
K	CI	30	CI	Catastrophic Illness
L	CH	32	--	Child Health
M	CW	11	MM	Child Welfare
N	ME	33	--	Medical Eye Care
Q	RA	12	MM	Cat. Needy-Aged
R	RB	13	MM	Cat. Needy-Blind
S	RD	14	MM	Cat. Needy-Disabled
T	RF	17	MM	Cat. Needy-AFDC Relat.
U	HH	--	--	Head of Household
V	MA	06	MM	Medical Only-Aged
W	MB	07	MM	Medical Only-Blind
X	MD	08	MM	Medical Only-Disabled
-	DE	31	--	Drugs for the Elderly
-	FF	04	MM	AFDC-Money Pay.(Adult)
-	FF	05	MM	AFDC-Money Pay.(child)
-	FM	15	MM	AFDC-No Money (Adult)
-	FM	16	MM	AFDC-NO Money (Child)

Feeder Reports

HCFA120 REPORTING
HMGR521-HMGR526

The HMGR521 through HMGR526 reports are designed to meet HCFA120 federal reporting requirements. The following subsection consists of a definition section on each of the MARS produced reports. This subsection is broken down as follows:

HMGR521 136
HMGR522 140
HMGR523 144
HMGR524 148
HMGR525 153
HMGR526 157
Federal/State Categories of Service 161

HCFA120 Federal Reporting Instructions (See Appendix following page 235.)

DEFINITION—HMGR521

Title: Monthly Statistical Report on Medical Care

Part I -

Section B. Distribution of Medical Vendor Payments by Type of Service and Program.

MMIS Output Number: There is no corresponding report in the MARS Operational Techniques.

Distribution: Required Reporting

Frequency: Monthly

Sequence: Program, Type of Service

Purpose: To provide reporting information for Form HCFA-120 Part I, Section B, a monthly report on distribution of medical vendor payments by type of service and program.

Relationship to Other MARS Reports: This report, along with the HMGR522, HMGR523, HMGR524, HMGR525, and HMGR526 provides the necessary information for HCFA-120 reporting.

Organization: The HMGR521 presents a distribution of expenditures by Type of Service within each Program type. Total expenditures are presented for Title XIX, State Med Assistance, Other Non Title XIX, and Unassigned Program.

Exclusions: Denied Claims

Field Descriptions:

Title XIX—The amount of payments for types of services made under Title XIX during the report month. Included are payments for coinsurance and deductibles. Only payments which are Federally matched are reported.

State Med Assistance—The amount of payments from general assistance funds for medical services. Only payments from State funds are included.

Other Non Title XIX—The amount of payments from non Title XIX and non State funds for medical services. Payments from Title XIX and State funds are excluded.

Unassigned Program—The amount of payments from funds not classifiable under Title XIX, State Med Assistance. Cash control transactions are reported here.

See the appendix for definition of Federal Types of Service. (Page 236).

For [redacted] categories of service corresponding to the federal categories of service, see page 161.

Balancing Procedures: The sum of Total expenditures for all four program types should equal the Total Amount figure on County Report A (HMGR501). The two figures may vary slightly due to rounding on the HMGR521. There may be exceptions to this balancing at accounts with special requirements for input to the HCFA-120 or where the County Reports exclude data. This figure should also balance with the Net Amount of the MTD Summary of the Claims Payment Register (HMDR203I).

The HMDR201I from the claims payment register (CPR) is the category of service report produced each checkwrite. Based upon the Federal/State categories of service table, the sum of the HMDR201I Net Amounts for each category of service for each checkwrite in the MARS month, should balance with the corresponding categories of service on the HMGR521.

REPORT NUMBER - HMGR521I
DATE PREPARED - 05/31/83
TIME PREPARED - 16:19

MONTHLY STATISTICAL REPORT ON MEDICAL CARE
PART I

STATE -

REPORT FOR MONTH OF MAY, 1983

SECTION B. DISTRIBUTION OF MEDICAL VENDOR PAYMENTS BY TYPE OF SERVICE AND PROGRAM

PROGRAM	TOTAL	INPATIENT HOSPITAL	INPATIENT MENTAL HEALTH FACILITY SERVICES			I C F	
			MENTAL HOSPITAL FOR THE AGED	SNF/ICF FOR THE AGED	INPATIENT PSYCH FACILITY AGE 21 AND UNDER	MENTALLY RETARDED	ALL OTHER
1. TITLE XIX	$6,167,233	$1,270,136	$0	$0	$0	$1,226,411	$1,453,283
2. STATE MED ASSISTANCE	$0	$0	$0	$0	$0	$0	$0
3. OTHER NON TITLE XIX	$0	$0	$0	$0	$0	$0	$0
4. UNASSIGNED PROGRAM	$64,636-	$94,635-	$0	$0	$0	$7,036-	$59,773

	S N F	PHYSICIAN	DENTAL	OTHER PRACTITIONER	OUTPATIENT HOSPITAL	CLINIC	HOME HEALTH
1. TITLE XIX	$677,452	$537,724	$90,925	$15,258	$266,028	$0	$23,809
2. STATE MED ASSISTANCE	$0	$0	$0	$0	$0	$0	$0
3. OTHER NON TITLE XIX	$0	$0	$0	$0	$0	$0	$0
4. UNASSIGNED PROGRAM	$20,021	$14,878-	$140-	$490-	$20,237-	$0	$622-

	FAMILY PLANNING	LAB AND X-RAY	PRESCRIBED DRUGS	E P S D T	RURAL HEALTH CLINIC	STERILIZATION	OTHER CARE
1. TITLE XIX	$12,664	$78,071	$256,457	$16,679	$2,721	$23,135	$216,480
2. STATE MED ASSISTANCE	$0	$0	$0	$0	$0	$0	$0
3. OTHER NON TITLE XIX	$0	$0	$0	$0	$0	$0	$0
4. UNASSIGNED PROGRAM	$356-	$236-	$264-	$0	$0	$0	$5,537-

	UNASSIGNED TYPE OF SERVICE
1. TITLE XIX	$0
2. STATE MED ASSISTANCE	$0
3. OTHER NON TITLE XIX	$0
4. UNASSIGNED PROGRAM	$0

ADJUSTMENT PAYMENTS INCLUDED IN PART I, SECTION B WITH UNASSIGNED TYPE OF SERVICE - $0.00

ADJUSTMENT PAYMENTS INCLUDED IN PART I, SECTION B WITH ASSIGNED TYPE OF SERVICE - $44,557.64

Attachment D

Data Cell Values

FORM	PAGE	COLUMN	*CELL(s)	POINT VALUE(per cell)
HCFA-2082	A01 & A05	1	01-01	10 pts
	A01 & A05	1	02-01 through 21-01	5 pts each
	A01 & A05	2	01-02 through 21-02	4 pts each
	A01 & A05	3	01-03 through 21-03	1 pt each
	A01 & A05	4	01-04 through 21-04	1 pt each
	A01 & A05	5	01-05 through 21-05	1 pt each
	A02 & A06	6	01-01 through 21-01	4 pts each
	A02 & A06	7	01-02 through 21-02	4 pts each
	A02 & A06	8	01-03 through 21-03	4 pts each
	A02 & A06	9	01-04 through 21-04	4 pts each
	A02 & A06	10	01-05 through 21-05	2 pts each
	A03 & A07	11	01-01 through 21-01	1 pt each
	A03 & A07	12	01-02 through 21-02	3 pts each
	A03 & A07	13	01-03 through 21-03	2 pts each
	A03 & A07	14	01-04 through 21-04	2 pts each
	A03 & A07	15	01-05 through 21-05	2 pts each
	A04 & A08	16	01-01 through 21-01	1 pt each
	A04 & A08	17	01-02 through 21-02	3 pts each
	A04 & A08	18	01-03 through 21-03	1 pt each
	A04 & A08	19	01-04 through 21-04	1 pt each
	A04 & A08	20	01-05 through 21-05	1 pt each
	A09 & A12	---	All Cells	½ pt each
	A10 & A13	---	All Cells	½ pt each
	A11 & A14	---	All Cells	½ pt each
	A15	---	All Cells	2 pts each
	A16	---	All Cells	2 pts each
	A17	---	All Cells	2 pts each
	A18	---	All Cells	2 pts each
	A19	---	All Cells	2 pts each
	A20	---	All Cells (excluding shaded cells)	½ pt each

* Data cell numbers refer to the cell designations printed in each cell on the HCFA-2082

FORM	PAGE	COLUMN	*CELL(s)	Point Value (per cell)
HCFA-120	M01	—	01-01	18 pts
	M01	—	01-02 through 01-07	3 pts each
	M01	—	03-01	30 pts
	M01	—	03-02	12 pts
	M01	—	03-03 through 03-05	3 pts each
	M01	—	03-06 and 03-07	12 pts each
	M01	—	05-01 and 05-02	12 pts each
	M01	—	05-03	6 pts
	M01	—	05-04	3 pts
	M01	—	05-05	9 pts
	M01	—	05-06 and 05-07	6 pts each
	M01	—	07-01	6 pts
	M01	—	07-02	3 pts
	M01	—	07-03	9 pts
	M01	—	07-04 through 07-07	3 pts each
	M01	—	09-01 and 09-02	1 pt each
	M01	—	10-01 and 10-02	1 pt each
	M02	1	02-01 through 21-01 (excluding shaded cells)	2 pts each
	M02	2	02-02 through 21-02 (excluding shaded cells)	2 pts each
	M02	3	02-03 through 19-03 (excluding shaded cells)	½ pt each
	M03	--	All Cells (excluding shaded cells)	2 pts each
	M04	--	All Cells (excluding shaded cells)	5 pts each
	M05	--	All Cells	½ pt each
	M06	--	All Cells	½ pt each
	M07	--	All Cells	½ pt each

*Data Cell numbers refer to the cell designations printed in each cell on the HCFA-120

Department of Health and Human Services
Health Care Financing Administration

Page	A02	STATE
State		
Month		
Year		

STATISTICAL REPORT ON MEDICAL CARE: RECIPIENTS, PAYMENTS, AND SERVICES
Section A(2). Recipients of Medical Care by Type of Medical Service, and by Maintenance Assistance Status and Basis of Eligibility *(Continued)*

Fiscal Year 19 ____

Maintenance Assistance Status of Recipient and Basis of Eligibility for Medical Care	ICF Services: For Mentally Retarded (6)	ICF Services: All Other (7)	SNF Services (8)	Physicians' Services (9)	Dental Services (10)
1 Total Number of Medical Care Recipients	(01 01) 4	(01 02) 4	(01 03) 4	(01 04) 2 4	(01 05) 2
2 Categorically Needy Receiving Maintenance Assistance, Total	(02 01) 4	(02 02) 4	(02 03) 4	(02 04) 4	(02 05) 2
a Aged	(03 01) 4	(03 02) 4	(03 03) 4	(03 04) 4	(03 05) 2
b Blind	(04 01) 4	(04 02) 4	(04 03) 4	(04 04) 4	(04 05) 2
c Disabled	(05 01) 4	(05 02) 4	(05 03) 4	(05 04) 4	(05 05) 2
d Children in Families with Dependent Children	(06 01) 4	(06 02) 4	(06 03) 4	(06 04) 4	(06 05) 2
e Adults in Families with Dependent Children	(07 01) 4	(07 02) 4	(07 03) 4	(07 04) 4	(07 05) 2
3 Categorically Needy not Receiving Maintenance Assistance, Total	(08 01) 4	(08 02) 4	(08 03) 4	(08 04) 4	(08 05) 2
a Aged	(09 01) 4	(09 02) 4	(09 03) 4	(09 04) 4	(09 05) 2
b Blind	(10 01) 4	(10 02) 4	(10 03) 4	(10 04) 4	(10 05) 2
c Disabled	(11 01) 4	(11 02) 4	(11 03) 4	(11 04) 4	(11 05) 2
d Children in Families with Dependent Children	(12 01) 4	(12 02) 4	(12 03) 4	(12 04) 4 2 4	(12 05) 2
e Adults in Families with Dependent Children	(13 01) 4	(13 02) 4	(13 03) 4	(13 04) 4 2 4	(13 05) 2
f Other Title XIX Recipients	(14 01) 4	(14 02) 4	(14 03) 4	(14 04) 4	(14 05) 2
4 Medically Needy, Total	(15 01) 4	(15 02) 4	(15 03) 4	(15 04) 4	(15 05) 2
a Aged	(16 01) 4	(16 02) 4	(16 03) 4	(16 04) 4	(16 05) 2
b Blind	(17 01) 4	(17 02) 4	(17 03) 4	(17 04) 4	(17 05) 2
c Disabled	(18 01) 4	(18 02) 4	(18 03) 4	(18 04) 4	(18 05) 2
d Children in Families with Dependent Children	(19 01) 4	(19 02) 4	(19 03) 4	(19 04) 4	(19 05) 2
e Adults in Families with Dependent Children	(20 01) 4	(20 02) 4	(20 03) 4	(20 04) 4	(20 05) 2
f Other Title XIX Recipients	(21 01) 4	(21 02) 4	(21 03) 4	(21 04) 4	(21 05) 2

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